

**An exploratory study of the lived
experience of newly appointed Health
Care Assistants (HCAs) during their first
six months in a role within an Acute
Hospital setting.**

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Abstract

This research focuses on the lived experience of newly appointed Health Care Assistants during their first six months in a role within an acute hospital setting.

The focus of this research is unique in that it is a UK based study involving Health Care Assistants newly employed in an acute NHS Hospital. It is timely in that it coincides with the potential for development of the non-registered nursing workforce in the United Kingdom and comes at a time when the Health Care Assistant role is in the spotlight.

The study used a phenomenological hermeneutic interpretative approach based on the theoretical concepts of Heidegger, in order to explore the lived experience of twelve Health Care Assistants during their first six months of employment. In depth semi-structured interviews were carried out at 3-4 weeks and again at six months into their role. The interviews were analysed separately, and then reviewed as a whole. Key themes consistently emerged around: Belonging, Becoming an Insider; Positively Becoming and a Sense of Self. These themes were explored in relation to existing research and theoretical frameworks around starting a new role at work. The study concludes that the experiences of the health care assistants have a resonance with the concept of Transition in nursing and also with theories that have evolved through the study of apprenticeship, in particular the theories of Newcomer Adjustment and Legitimate Peripheral Participation. This led to the idea of 'Belonging to their role' and 'Belonging to their ward' as two interrelated concepts that frame the lived experience. A framework for the experience of newly appointed Health Care Assistants to acute hospital care is proposed which suggests that this group of staff would benefit from an induction and on-going support that recognises their unique experiences that straddle those of student nurses and those of more traditional work placed learners. Fostering a sense of belonging and developing the ward as a place to develop and learn is identified as important. The study provides suggestions for clinical practice, education, policy and future research.

Dedication

This thesis is dedicated to the twelve health care assistants who took part in this study and who gave of their time and spoke so freely and honestly to me on two occasions. It was a privilege to hear their stories and enable their voices to be heard beyond the confines of their wards. I can only hope that I have done justice to their accounts and that in some way I helped them in their first six months in their new role. I hope that they get the chance to witness how knowing more about their experiences can begin to change the experiences of future health care assistants new to roles in acute hospital care. I wish them well for their future.

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Overview of the thesis

This thesis presents a research journey that explores the lived experiences of health care assistants (HCAs) during their first six months in a role within an acute hospital setting. The author is a nurse and this study is set within a context of nursing. Throughout it is informed by nursing research literature, although the wider literature also has influence, particularly in the final chapters. In line with the phenomenological approach underpinning this study, the researcher's thoughts and rationale behind methodological decisions are articulated, including personal reflections which are interspersed throughout the thesis. This is to give the reader an insight as to how the researcher's personal perceptions and understandings impacted on the study. Having a scientific background and some previous experience with academic writing, using the third person passive voice was the style of writing the author felt most comfortable with and this is used throughout the study, except for the first person personal reflections that are interspersed within the text.

The following summary provides an overview of the structure of the thesis and gives an outline of the content of each chapter.

Chapter 1: Background to the Study. An overview of the role of the non – registered nursing workforce in the United Kingdom is provided in order to set the scene for the research question that explores the experiences of a group of newly appointed health care assistants (HCAs) within a large National Health Service (NHS) acute teaching hospital in the East Midlands. The chapter highlights the potential significance for developments in the HCA role for the hospital ward of the future and draws attention to the fact the current spotlight on the recruitment and retention into this role warrants an increased focus.

Chapter 2: Preliminary Literature review. A review of the literature on the HCAs working in acute hospital care is presented which identifies that there is a paucity of literature on the experiences of HCAs going through changes in role in an acute care environment. In line with the philosophy underpinning the

research, an in depth review of the literature on the experience of role change is not presented here, although the key concepts are highlighted.

Chapter 3: Research Methodology. The rationale for selecting a qualitative approach to the study is briefly outlined and the decision to base the study on a phenomenological foundation justified. There is a focus on Husserl's transcendental phenomenology and Heidegger's hermeneutic phenomenology in order distinguish between the two and determine the approach for the research method. The rationale for selecting Heideggerian Hermeneutics as the interpretative approach to phenomenology in this study is provided, including a review of the use of this approach in the nursing research identified in the literature search.

Chapter 4: Research method. An overview of the development of the research method from the conceptual parameters of the underlying research philosophy is provided. The work of the Canadian Phenomenologist van Manen (1990, 1997, 2006, 2014) is introduced which informs the research method. The stages of the research process, including a section detailing the approach to the analysis and the justification for using software to support the analysis stage is presented. The chapter ends with an outline of the measures taken to provide assurance as to the quality of the research.

Chapter 5: Study findings. The findings from the two sets of interviews are presented. Each set of interviews are put into context and the findings for each presented as discrete entities and summarised for a particular moment in time for the participants. This begins with a description of emerging themes, leading to the identification of key interpretative themes for the lived experience of the participants. Four key interpretative themes were identified for each set of interviews (3-4 weeks and six months) and these are presented separately, illustrated by direct quotes from the participants.

Chapter 6: The lived experience over time. The findings from the two study time frames are then looked at together with an exploration of overarching, emerging and diminishing themes between and across the two sets of

interviews. This was done in order to better understand the experience of the participants over the six month period of the study and was a decision made after analysing the two sets of interviews separately. Key interpretative themes consistently emerged around: **Belonging, Becoming an Insider; Positively Becoming and a Sense of Self**. The nursing literature around experiences within new roles is then reviewed in depth in order to highlight how the key themes from this study resonate with what is already known.

Chapter 7: Discussion. This chapter begins by considering in more depth existing research and theoretical frameworks around Transition in nursing and the experiences of nurses starting in a new role. The four key interpretative themes are reviewed in relation to the literature on Transition in nursing which is found to have some, but not complete resonance to the experiences of the study participants. The chapter then explores the wider literature on starting a new role in relation to the study themes, and highlights the literature around becoming an insider, newcomer adjustment and the proactive newcomer. This leads to the theory of Legitimate Peripheral Participation which has been developed largely through the study of apprenticeship. There is a growing appreciation that the lived experience of the HCAs taking part in the study straddles the experiences of those new to roles within nursing and also those within apprenticeships beyond the world of nursing. The chapter presents a visual representation of the key components of the theories of Transition, Newcomer Adjustment and Legitimate Peripheral Participation in relation to the key study themes.

Chapter 8: Study Conclusion. This chapter brings the reader back to the philosophical underpinnings of the study and reminds the reader of the limitations of the study that have been presented in earlier chapters. The findings of the study are summarised and ideas articulated in the discussion conceptualised into the two higher order constructs of 1.Belonging to their place of work- the ward and 2.Belonging to their role- that of an HCA on their ward .It is acknowledged that existing models around the experience of role change within a work environment do not completely represent the study findings and

so the framework developed from the study is a new conceptual framework and a unique contribution to the knowledge of the experiences of HCAs commencing a role in hospital acute care. There is a focus on a secondary aim of the study in highlighting factors that have the potential to inhibit and facilitate the experience of HCAs as they start their new roles. Finally, the chapter presents recommendations from the study including the implications for practice and policy and makes suggestions for future research.

Glossary of Terms

Agenda for Change	Grading and pay system for all National Health Service staff except doctors. Staff are placed in one of nine pay bands on the basis of their knowledge, responsibility, skills and effort needed for the job. The assessment of each post using the Job Evaluation Scheme determines the correct pay band. The participants in this study were on Band 2 of this pay system. The Researcher is a Band 8a
Acute Hospital Care	Where a patient receives active but time limited treatment for a severe injury or episode of illness, an urgent medical condition, or during recovery from surgery. In medical terms, care for acute health conditions is the opposite from chronic care, or longer term care.
Buddy	A HCA who has been in post for at least two years, who is nominated by their line manager and has attended a training day. Buddys provide one to one mentorship and support for new HCAs in the clinical area under the supervision of the registered nursing team.
Non- Registered Nurse – can be identified by the following terms: Health Care Assistant HCA Nursing Auxiliary Care Assistant Care worker Support worker Health care support worker Non/non registered nurse Health Care Assistant Unlicensed nurse Practical nurse	A person within the nursing team without professional regulation who works under the guidance of a registered professional. There are a variety of names for this role. In the context of this study the role was that of health care assistant (HCA). The study HCAs were working in an acute hospital clinical area under the supervision of a registered nurse.
Hermeneutic Phenomenology	Hermeneutic phenomenology is concerned with identifying, describing and interpreting everyday lived experiences (in context). The aim is to discover meaning and reach a sense of understanding. The focus on meaning and understanding can be linked to Heidegger's philosophy of interpretive phenomenology.
Supernumerary	Where a member of staff works in their clinical area but is not counted within the staff numbers for that shift. Supernumerary HCAs work alongside their Buddy and are supervised and supported in practice. A green supernumerary badge indicates the supernumerary status.

Prologue:

Setting the scene and foreshadowing- A personal perspective and formation of the research interest.

The writing of this study comes after almost forty years' experience working with people in a nursing capacity and is a significant point on a personal journey. I have included this section at the start of this thesis as I wanted to give the reader an insight into the experiences and reasoning behind the study and set the scene for what is to follow.

My experiences of working with individuals in a caring capacity began at school in the sixth form when we were encouraged to find something to occupy Wednesday afternoons that could be classed as personal development with a potential link to future work plans. My first experience with the National Health Service was on the wards of a local psychiatric hospital working as a volunteer with the elderly long term patients. I have clear recollections of spending afternoons talking to these individuals, playing cards, helping them to the toilet, brushing their hair, helping them with their meals. I also remember feeling completely bewildered on my first afternoon when no one took the time to show me around or explain anything about who the patients were or what I was supposed to be doing with them. I felt out of my depth and could not see how I could possibly be of any use to either the patients or to the staff. It was not until a more seasoned volunteer took me under her wing and enabled me to see what could be done and what I could do that I started to release the potential for me to make a difference in three hours of an afternoon. This experience was the catalyst that finalised my decision to use the three science subjects taken at A level to apply for a degree in nursing.

After sixth form and with a place on a nursing degree course dependent on my A level results, I worked for three months as a care assistant in a local nursing home for the elderly. Armed with confidence from my volunteering, I started on my first shift only to realise early on that this was very different work. Many of the patients were in many ways similar to those that I had met during my volunteering work, but they were also frail and dependent on someone to help them with their activities of living. The work was physically hard and could be emotionally draining. The nursing home provided me with someone to shadow for the first week and at the end of the each month the Matron of the home met with me and encouraged me to give feedback. I left this role with awareness that caring roles were different depending on the context. I also gained an appreciation of the hard work and camaraderie of a close knit team and an understanding of the importance of having someone show an interest in my experiences.

Whilst studying for my nursing degree as a 'university nurse' I was sometimes placed on wards where they were not used to taking students and where I was the only 'learner'. It could feel isolated and even at the end of a placement I never really felt part of the team. I was often put to work with the nursing auxiliaries who stereotypically were middle aged women with life experience

who knew the running of the ward and steered me in the direction of how things should be done. I learnt a great deal about working with people and caring for the sick as a result of the warmth, common sense and good humour of these women.

As a registered nurse I have had a clinical career in the acute hospital care sector, working in geriatrics (as it was then called), medicine and coronary care. Over this time I have come to recognise how the non-registered nursing work force can contribute significantly to the care of patients. I have seen how they are the ones at the bedside with the patients, getting to know them and their families and helping them through the day. They are often the eyes and ears of the registered nursing team and can provide a level of normality and consistency in a busy acute care environment.

I have worked as a nurse in practice development for the latter part of my nursing career and during this time I have been involved in supporting the learning and development of health care assistants. Working on an early induction programme, I began to appreciate the enormity for some in making the move to a role within an acute care hospital environment. I have listened to experiences, both good and bad, from health care assistants during their first few weeks at work and have come to respect how challenging this time can be. I have listened as some have told me of their decision to leave after only a few weeks and heard from others that becoming a health care assistant on a busy ward is the best thing that they have ever done. A key factor in these accounts seemed to be the initial experiences of the health care assistants in their clinical areas.

Over the years I have gained an understanding of the part that health care assistants can make to the nursing team and some appreciation of what it is to work in the role. From personal experience I can empathise with the significance of joining a new team in a new role. Making the decision to develop a research question that aimed to explore the lived experiences of health care assistants in their first six months in an acute hospital care role was not a difficult one. It was made more straightforward by a realisation that there was limited literature on the subject and by a growing appreciation of the potential significance of the non-registered nursing workforce in the acute hospital ward of the future.

R.A.W. April 2015



The Author after finishing a shift as a HCA in a nursing care home.



The Author leading a study session for HCAs working in an acute hospital trust

1977

2015

1: Background to the Study

1.1. Introduction

The personal reflection at the start of this study has set the scene for its focus and given an insight into the evolution of the research question. It was intended from the outset that the focus of the research would be the experiences of health care assistants (HCAs) who were newly appointed into the wards of a large National Health Service (NHS) acute teaching hospital in the East Midlands where the author is employed. This chapter will provide a background to the role of HCAs in the United Kingdom in order contextualise the study and highlight the foundations of the research question and the aims and objectives of the study.

1.2. The nursing workforce in the UK

Within the United Kingdom (UK) it is the nursing workforce that is at the forefront of delivering direct care to patients. This workforce is diverse, spans the whole health care community and forms the largest percentage of those employed in healthcare services (Cavendish 2013). Traditionally, and for the purpose of this study, the UK nursing workforce is categorised in respect of whether or not there is a statutory role requirement for national registration. Those roles that are registered are regulated in terms of entry requirements, a code of practice, continued demonstration of competence and protected job title (Department of Health 2009).

In the UK, those who have undergone recognised training and who have met predetermined educational, clinical, personal and professional standards have their details held on a central data base held by the Nursing and Midwifery Council (NMC). The headcount of nurses registered with the NMC is currently over 690,000 with approximately half of these employed by the National Health Service (NMC 2017).

Those (the larger group), who provide nursing care for patients but who are not on the above register, have a range of roles and have traditionally had a limited, uncoordinated and unrecognized career structure (Cavendish 2013).

There are over 1.3 million non-registered front line nursing care staff who make up around a third of the caring workforce in hospitals and who, it has been estimated, currently provide over 60 per cent of hands on patient care (Willis 2015). This group of staff have been known by a variety of names including unqualified nurse, unregistered nurse, nursing auxiliary, nursing aide, care assistant, support worker and health care assistant which, it has been acknowledged, has led to some confusion and blurring of boundaries around their role (Hasson et al 2013a, Waldie 2010, Kessler et al 2012, RCN 2015) and led to challenges when researching the background for this study.

In the acute NHS Trust which forms the backdrop for this study, this group of staff are referred to as non-registered nurses -for reports and workforce analyses; and Health Care Assistants (HCAs) at ward level. In this study the term non-registered nurse will be used as a generic term and the term HCA used for the study participants. Other titles will be used as they are referred to within the context of the text.

1.3. A brief history of the HCA Role

The range of titles, inconsistent records and the lack of a National data base all hinder the search for evidence on the background of the HCA role (Kessler et al 2012). Reviewers have sought chronological clarity by linking the development of the non-registered nursing role to known developments in other nursing roles. Indeed the development of the non-registered nursing role has been acknowledged as being significant in the evolution of nursing itself (Edwards 1997, Stokes and Warden 2004, Waldie 2010) with the distribution of nursing care tasks and responsibilities within a hierarchical structure being deeply rooted in many years of nursing practice (Kessler et al 2012).

Nursing as a recognised role is said to have its origins around the time of the Crimean war in the 1850s and the role of the assistant nurse can also be traced back to this period (Stokes and Warden 2004). Nursing was established as a registered and regulated profession under the 1919 Health Care Act with a continued reliance on the untrained nurses- known as auxiliary nurses - to

support the delivery of nursing care (Glasper 2017). In the late 1930s it was recognised that many untrained nurses were providing levels of care similar to that of registered nurses and it became possible to undertake a two year course to become a recognised assistant nurse. This evolved into the role of the State Enrolled Nurse (SEN) in 1961, a role which had National recognition as those with the title had their names recorded on a Roll of Nurses (Webb 2000), which would subsequently evolve into a register held by the General Nursing Council.

The nursing auxiliary role and that of the SEN existed in tandem for several decades until SEN training was discontinued in the 1990s. This coincided with the reorganisation of nurse training known as Project 2000 (United Kingdom Central Council - UKCC- for Nursing, Midwifery and Health Visiting 1986). Student nurses were granted supernumerary status and moved away from an apprentice style model of training with non- registered nurses taking on many of the tasks traditionally undertaken by student nurses. It is acknowledged that this created a gap in the nursing workforce that acted as a catalyst for the subsequent rapid expansion of the number of non- registered nurses and with the title of nursing auxiliary being gradually replaced by that of Health Care Assistant (HCA) role (Glasper 2017) .

At the time of the NHS Agenda for Change (AfC) review into job roles and pay bandings designed to bring consistency across the NHS (NHS Employers 2005) HCAs were allocated Bands 1-3 on the Agenda for Change (AfC) framework; the level of grading being determined largely by clinical skills required in the role, although the grading of HCAs by clinical role, pay band and financial remuneration remained nationally variable with continued variations in the roles between hospital Trusts (Bach et al 2008).

The professional body for registered nurses in the UK- The Royal College of Nursing (RCN) issued a position statement over a decade ago for registration of HCAs and in recognition of the evolving role of the non- registered nursing work and an acknowledgement of the blurring of roles and responsibilities allowed full membership of the college to health care support workers in 2011 (RCN 2011).

1.4. The HCA role today and drivers for change.

The HCAs starting their employment today in acute hospital care are entering an ever evolving health care environment. The drivers that impact on the role are complex and multi-faceted and have influenced the numbers of HCAs employed in the National Health Service (NHS), the skill mix at ward level and the roles that HCAs now undertake. Whilst these drivers are presented below as discrete entities there is inevitably overlap between them.

1.4.1. Population Demographics: an ageing population and increasing complexity of disease are placing ever increasing demands on the health service which is preparing for major programmes of change in order to transform how care is delivered (NHS England and others 2014). As is acknowledged by the senior nursing hierarchy in the Compassion in Practice document (DH 2012), those that provide nursing care (including the non-registered workforce) are facing the complex challenge of more people to support, many with complex care needs and with higher expectation of what can and should be delivered .

1.4.2. Political climate: The remit and scope of nursing care roles are embedded in the political economy of health care delivery and any large scale change in role tends to be politically driven. It has been argued that whilst policy makers have historically failed to recognise the non- registered nursing role strategically- this position is now changing as practitioners and policy makers increasingly view the non- registered roll as central to a variety of service and other organisational objectives (Cavendish Review 2013, Glasper 2017, Kessler et al 2012, NHS England 2017, Willis 2015).

1.4.3. Economic drivers: The NHS Improvement Business plan 2017-2019 (NHS 2017) highlights the challenges faced by health care providers in transforming services in order to improve the quality of patient care and

increase productivity, whilst at the same time being responsive to the prevailing economic conditions. This is in the context of a global economic downturn that has coincided with increased demands for hospital services alongside difficulties in recruiting and retaining health care workers. Hospital Trusts have had to review their recruitment strategies and workforce skill mix which has a direct impact on clinical roles at the patient's bedside – including the non-registered nursing workforce (Cavendish Review 2013, National Audit Office 2016, NHS England 2015, 2017).

1.4.4. An increased focus on quality: The Nursing Roadmap for Quality (DH 2010) focused on strategies for nurses to understand the quality agenda and the tools to provide quality care. This work was developed through recommendations from the Nursing and Care Quality Forum (DH 2012), NHS Improvement Business plan 2017-2019 (NHS 2017), and the Francis Report on Mid Staffordshire Foundation NHS Trust (Mid Staffordshire NHS Foundation Trust Public Inquiry, 2013) which emphasised the importance of getting the 'basics right' and being able to give assurance that care was of a consistently high-quality. There has been an emphasis on compassion with a need for assurance that care was effective and safe. This focus on quality was developed through a vision and strategy for nurses, midwives and care-givers which sets out a framework for caring behaviours (NHS Commissioning Board & DH, 2012), and the Willis Commission (2012). Subsequently recommendations that the status of caring be raised with an emphasis on a need to 'get the basics right' was outlined by the Cavendish Review (Cavendish 2013). This report highlighted the need to have an appropriately trained workforce in order to achieve this aim, and for reviewing the skill mix, (including that of the non- registered workforce), at ward level.

1.4.5. Work force developments: There is currently a focus on staffing levels and skill mix within the nursing workforce. (National Quality Board 2013, NHS England 2017, NHS Improvement 2016, The Health Foundation 2016). Several workforce trends have taken registered nurses away from delivering direct patient care, which in turn have had a knock on effect on the role of the non-

registered nursing workforce. These include: a reduced supply of registered nurses; registered nurses taking on more medical roles and registered nurses undertaking more administrative work. It has been reported that unregistered nurses now spend more time than registered nurses at the bedside (Cavendish Review 2013). A detailed three-year study (Kessler Heron and Dopson 2010), found that the “core” of patient care had shifted from tasks performed by nurses to those performed by HCAs. This study involved ward observations and interviews with over 1,000 staff and patients. It found that HCAs spent the majority of their time on a typical early shift carrying out patient care, whereas nurses spent the largest proportion of their time on organisational tasks such as answering the phone and handovers. This supports a view that nurses have been substituted by HCAs in some areas of nursing care and places the role of the non-registered nursing workforce in the spotlight (Cavendish Review 2013). The key factors behind this are discussed briefly below.

1.4.5.1. A reduced supply of registered nurses: Despite the emphasis on safe staffing since the publication of the Francis Report (2013) the number of Registered Nurses working in the NHS is falling. Recent figures NMC (2017), show an increase in the number of nurses and midwives leaving the national register while at the same time, numbers joining have slowed down. This is in a climate where there is established evidence that a work force with a high registered nurse to patient ratio improves clinical outcomes for patients in hospital (Ball and Catton 2011, Carr-Hill et al 1992, Keogh 2012, Thungjaroenkul et al, 2007, Twigg et al 2016). There is also related evidence that bachelor’s education for nurses could reduce preventable hospital deaths (Aiken et al 2014). Despite this student nursing commissions have not kept up with the need for registered nurses. Retention has been a growing issue as more nurses leave their jobs and one in three nurses are due to retire in the next decade (Migration Advisory committee 2016).

Action to manage NHS Registered nursing supply shortfalls has tended to be managed locally and has focused on skill mix reviews/service reconfiguration, local and overseas recruitment campaigns and use of agency/temporary staff

(Health Education England Nursing Supply Steering Group 2014). However, the option of relying on overseas nurses is now limited due to the introduction of more stringent immigration policies and the fallout from the decision for the UK to leave the European market (Public Policy Network 2012, Migration Advisory Committee 2016).

1.4.5.2. The changing role of the registered nurse: Historical accounts of contemporary nursing care (Edwards 1997) highlight that it changed considerably in the 21st century, particularly in terms of the roles and responsibilities. Today registered nurses are spending less of their time giving fundamental bedside care to patients as they take on more extended & medical roles. They are also spending more time on administration and paper work (RCN survey 2013). This has contributed to the shift towards the non-registered workforce carrying out a greater proportion of this fundamental care for patients (Cavendish Review 2013, Glasper 2017).

A significant catalyst for the change in the working practices of registered nurses has been linked to developments in the working practices of medical staff. The European Working Time Directive was produced by the Council of the European Union in 1993 and incorporated into British law registered nurses extending their roles and undertaking tasks traditionally carried out by medical professionals (Kessler et al 2010). This was seen as a positive step for modernising nursing careers with registered nurses working across boundaries and the creation of new specialist roles (NMC 2007). However, this shift in role responsibilities has gone hand in hand with a decreased time spent by registered nurses in direct patient care (Kessler et al 2010) adding to the impetus for this care to be provided by the non-registered nursing workforce.

1.4.5.3. Increased numbers of non- registered nurses: The fall in the number of Registered nurses has in part been balanced by an increase in the number of non-registered nurses. It has been reported that there was a 26 percent rise in the number of HCAs in the decade from 2002 to 2012 (Kessler et al 2012).

Workforce data from the Health and Social Care Information Centre (Health and Social Care Information Centre (2012) shows that, in the 12 months between September 2011 and 2012, the number the number of HCAs in England rose by 2,691 whilst the number of Registered nurses fell by a similar amount (Health and Social Care Information Centre (2012). Locally, the NHS Trust where this study was carried out has created HCA posts in an attempt to reduce the impact of Registered Nurse vacancies at ward level.

1.5. Development of the non-registered workforce:

It can be seen from the factors above, that the role of the non- registered nurse has long had an impetus to evolve in order to support the delivery of nursing care. However, until relatively recently, this opportunity has not been fully realised. For many years the development of the role sat within the constraints of the band 2 Agenda for Change (AfC) pay banding and job description- although ad hoc opportunities for progression to higher bandings did occur to meet service need, particularly in more acute care areas (Bach et al 2008, Kessler et al 2012, Glasper 2017, McGloin and Knowles 2005). A personal audit undertaken in the trust where this study was conducted of the Band 2 HCA role in 2010 highlighted a wide disparity in the clinical skills, levels of responsibility and expectations of the HCA role even though they were all nominally working to the same job description. This ranged from HCAs removing chest drains in one surgical area to them having virtually no direct patient contact in an intensive care area on the same hospital site.

For those looking to the non- registered nursing role as a possible job move, the Royal College of Nursing webpage (RCN 2015) highlights that HCAs are considered to be the bedrock of the nursing service and points out this group of staff deliver care in every imaginable setting and invariably are delivering the majority of hands-on nursing care. The Cavendish Review (2013) which used focus group interviews with health workers to inform the report, concluded that HCAs support registered nurses in a variety of ways and that many nurses see HCAs as an extra pair of hands, someone to whom they can delegate routine

tasks. Others felt that the best HCAs were their “eyes and ears”, feeding back information or picking up warning signs that something was wrong with a patient. In other cases, experienced HCAs were identified as an important source of support to student newly qualified nurses.

After the Francis Report and subsequent Cavendish review commissioned to examine the complexities and inconsistencies of HCA roles, there was an acknowledgment that these roles had gone without due recognition and attention for too long. The subsequent shift in focus resulted in recommendations and subsequent debate around training and supervision, career structure, professional regulation and the potential for progression to registered nurse training for this staff group (Willis 2015). It is now recognised (Health Education England 2016), that HCAs are at the starting point of a career framework and that the skills and potential they bring underpins the future development of the nursing workforce.

Fundamental to this increased emphasis on realising the potential of the non-registered nursing workforce has been the development of new roles for the currently non-registered nursing workforce (Spilsbury 2011). Specifically the Assistant Practitioner (Dix 2015, Miller et al 2015, Spilsbury et al 2011) and the Nursing Associate (Willis 2015) roles which, in different ways, are intended to allow registered nurses the time to concentrate on focused clinical duties and to take a greater lead in decisions pertinent to holistic patient care (Willis 2015, DH 2016). Locally the formal development of the Nursing Assistant role has been an option for non-registered staff since 2014 with selected individuals being developed through a two year foundation degree programme to take on specific clinical duties in a defined clinical area. The Nursing Associate role was announced by the Department of Health in 2016, creating the role in response to workforce needs in the English health and care context. The role is intended to be that of a generic practitioner within the field of nursing, working in the full range of settings across health and care and acting as a “bridge” between existing non-registered health and care support workers and registered nurses

(NMC 2017). Test sites (which include the NHS trust where this study was conducted) started training future nursing associates in January 2017. The majority of UK health care providers have been involved in reviews of nursing skill mix and have plans to increase the use of the non-registered nursing workforce and to develop their roles, particularly into higher AfC pay bands (3 and 4) with more clinical responsibility (Centre for Work Force Intelligence 2013, Lees et al 2013, Glasper 2017). The national agenda for an apprenticeship route into nursing, for those for whom a conventional university based programme is inappropriate, is a further career options for the current non- registered nursing workforce (Glasper 2014). This unprecedented potential for career development within the HCA workforce is likely to create vacancies at band 2 level and thus impact on the recruitment into these posts.

1.6. Characteristics of the current HCA workforce

It has been noted (Kessler et al 2012) that individuals come to the HCA role with personal characteristics and life histories which distinguish them from registered nurses. The Health and Social Care Information Centre (Health) and National Minimum Data set (2011) identified that 84% of the non- registered work force in health care were female; the average age was 45 years and that 56% were on the AfC Band 2 pay scale. When compared to registered nurses, non- registered nurses are likely to have stronger local links and are more likely to work close to where they grew up (Kessler et al 2012). Research has highlighted (Kessler et al 2010) that many HCAs have previously been employed in retail or factory work. The Cavendish Review (Cavendish 2013) incorporated a survey which identified that 22% of the sample of non-registered nurses working in hospital settings had previously worked in caring roles in other nursing or residential settings. This figure is likely to increase as procedures for recruiting to non- registered nursing posts in hospitals increasingly ask for experience in a caring role as a prerequisite for shortlisting applicants.

1.7. Role of the HCA in Acute Hospital Care.

Non- registered nurses have long had a role to play in the care of acute patients in hospital (Spilsbury and Meyer 2004). A report commissioned by the RCN in 2006 (Healthcare Work Force Research Centre. University of Surrey) based on questionnaires and focus groups with non- registered nurses from two acute hospitals and ward managers from the same sites, concluded that the non-registered nurses were a valuable member of the ward team with high levels of job satisfaction. However there was an identified need for clarity over roles and responsibilities and for a clear structure for training and career progression.

It is acknowledged that the use of non- registered nurses in acute hospital care has increased in the decade since the above report due to the dynamics of the UK health care system, in particular the shortage of registered nurses, economic constraints and changes in the scope of registered nursing practice (Twigg et al 2016). Analysis from the Nuffield Trust suggested that a further 17,000 hospital beds would be needed in the five year period from 2014-2019 to cope with increased demand (Smith et al 2014).

Strategies to meet changing health care needs including closer working links between health and social care and the delivery of care closer to home mean that patients in hospital are often more acutely unwell than even a decade ago with subsequent implications for the work that non- registered nursing staff do in this environment. Caring for those in acute hospital wards is going to differ from caring for individuals in community residential settings or in their own homes and it has been acknowledged that the acute care setting affords HCAs the potential to take on additional skills and to contribute significantly to patient care delivery (Lees et al 2013).

1.8. Training and Development of the HCA workforce

It is recognised that the training and development of HCAs has long lacked standardisation and rigour (Health Education England 2015, Glasper 2014, Knob 2005, Webb 2011). Guidance for would be applicants (National Careers Service Job Profile 2014, RCN 2015) focuses on the caring nature of the role

and the opportunity to make a positive difference to people's lives. There is an emphasis on the fact that no formal qualifications are required and that there will be opportunity for development once in post. However, once employed, the induction, training and support for HCAs has been variable (Webb 2011), with much of it occurring informally and inconsistently in the clinical environment (McGuire et al 2007, Spilsbury and Meyer 2004).

Following the Francis report and subsequent Cavendish review there has been a move towards a coordinated and standardised approach to the training development of HCAs. Health Education England (2015, 2016) has taken the lead nationally to maximize the capabilities and contribution of these healthcare staff and has specifically highlighted the importance of valuing and developing their role. This work includes: establishing minimum training standards for HCAs; developing pathways for HCAs to enter nurse training and increasing the number of healthcare apprentices.

1.8.1. Recommendations for HCA training

The Cavendish Review (2013) made a number of specific recommendations about the training and support of HCAs including proposing that all HCAs receive the same basic training, based on the best practice that already exists in the system. The proposal stipulated a requirement that HCAs achieve a standard 'certificate of fundamental care' before they were able to care for people unsupervised. From April 2015 there was a National requirement for all HCAs without existing care experience to undertake a formal competency based development programme based round fifteen core competencies. This programme has become known as the Care Certificate.

The Care Certificate builds on and replaces earlier induction programmes: Common Induction Standards (CIS) and National Minimum Training Standards (NMTS). The standards within the Care Certificate incorporate the principles of The Code of Conduct for Healthcare Support Workers and Adult Social Care Workers in England and the Social Care Commitment, which are the social care sector's standards around providing people who need care and support with

high-quality services. It also incorporates the Chief Nursing Officer for England's '6Cs' of compassion, competence, communication, courage and commitment. The certificate is subdivided into 15 standards covering outcomes, competencies and expected standards of behaviour (Ashurst 2015) which need to be achieved in knowledge and practice within the first 12 weeks in post (HEE 2015). Despite the intention to create a standardised competency framework, the Care Certificate has been interpreted and adopted in different ways by different health care organisations (Gilding 2017, Peate 2015). There are no national guidelines for the initial induction, support, training and development of these staff. The Care Certificate was introduced for the first time at the NHS Trust where this study was carried in the spring of 2015 which coincided with the induction of cohort of HCAs eligible to take part in this study.

1.9. The Local Picture.

The NHS Trust where this study was carried out is one of the largest in England with over 1800 beds spread across three sites in a city centre location. The Trust is a tertiary centre for a range of services and has a National reputation for cancer, renal and cardio- respiratory care. It has a large Emergency Department (ED) in its central site and admits almost 90,000 patients as an emergency annually (Trusts Annual Report 2015/2016).

The Trust employs over 10,000 staff, however, in line with the National picture, it has shortfall in registered nurses, particularly on acute medical and surgical wards. This has resulted in a focused campaign to recruit nurses from Spain, Portugal and Ireland with over 400 nurses from these countries recruited in the two years since January 2014. In the same time period, the Trust has run targeted recruitment initiatives resulting in the recruitment of over 300 HCAs at AfC Band 2 level.

There are (January 2017) 1600 non-registered nursing staff in the Trust with 1300 of these being HCAs at AfC Band 2- the focus of this study. A breakdown of these by age reveals that 26% are under 30 and 57.2% are over 40 with 11%

being over 56 years of age. This has implications for future workforce needs as a significant proportion are likely to retire within the next few years. It is likely that strategies will need to focus on the recruitment, induction and subsequent retention of HCAs for the considerable future.

Historically, clinical teams have recruited HCAs into speciality areas based on vacancies in a specific area. However in recent years the concept of bulk recruitment has meant that large numbers of HCAs have been recruited as part of a single job advert for employment to the Trust as a whole. The job advert has stipulated that applicants must have had some experience of caring in either a personal or work related capacity and they are also required to pass a maths and English test on the day of the interview. Most applicants, whilst meeting the criteria for caring experience, have no experience of working in an acute hospital environment. Current recruitment initiatives have resulted in up to sixty HCAs starting their employment on the same day. The cohort of forty HCAs who formed the population sample for this study joined the Trust in May 2015 and underwent an 11 day induction programme (Appendix 8) in the first four weeks which (for the first time), incorporated sessions specifically focused on the Care Certificate competencies and with a requirement to complete an associated work book within 12 weeks of employment.

1.10. Aims and Objectives of the Study

The initial thoughts outlined in the prologue and the subsequent review of the history and current status of the HCA role presented above, reinforced the current significance of the HCA to the acute hospital care workforce and helped crystallise the research question and identify the aims and objectives of the study. The aim of the study was to explore the 'lived experience' of HCAs newly appointed to the role in an acute hospital setting. The objective was to gain a unique insight into the participant's experiences at two moments in time during their first six months in post; at 3-4 weeks and 6 months into their employment and also to highlight the factors that influenced this experience.

1.10.1. The research question.

The research question for this study was:

What are the lived experience of newly appointed Health Care Assistants (HCAS) during their first six months in a role within an Acute Hospital setting.

A secondary question was:

What factors influence the lived experience of newly appointed Health Care Assistants (HCAS) during their first six months in a role within an Acute Hospital setting.

It is envisaged that the findings from the study guided by the above research question will build on existing knowledge and provide further information on the factors that impact on the experience of these individuals. The findings will also inform further discussion and provide guidance for those involved in the induction of HCAs as they commence employment in an acute hospital care setting. It is anticipated that better understanding of the lived experiences of HCAs as they move into to a new role will also help ward teams identify ways in which they can offer support. This is likely to have a positive impact on job satisfaction and retention.

1.11. A personal perspective

Preparing this chapter has strengthened pre-existing conceptions that the role of the HCA is ever evolving in response to the changing health care climate. There is evidence that the role of the HCA in acute care has the potential to assume further significance as patients in hospital become more acute and the structure of the nursing workforce at ward level becomes more dependent on the AfC bands 1-4 roles. The review of the literature affirmed that personal experience locally mirrors the National picture in terms of recruitment and induction. I was particularly surprised by the demographics of the local HCA workforce and had not appreciated that so many were near to retirement age. . It seems to me that HCAs are a significant contributor to nursing care who have often been overlooked. We do not know what their experiences are as they join us as new HCAs in an acute care role. Preparing this chapter has provided

further impetus for a study that puts HCAs working in acute care into the spotlight. It affirms the rationale for focusing the research question on the experiences of HCAs new to a role in an acute care environment. The fact that the study coincides with introduction of the nationally recognised Care Certificate further attests to the timeliness of undertaking this study now.

The fact that I was carrying out the study whilst working as an Education and Practice Development nurse within an acute care trust had potential benefits. Whilst I no longer personally work with HCAs during their induction to the Trust, I do lead a team who do. This means that the study has the potential to produce findings that have a clear route back into service delivery and therefore the potential to directly influence practice.

1.12. Conclusion

This chapter has provided an overview of the background of the non-registered nursing workforce in the UK and has highlighted the aims and objectives of the study. Justification for the study focus, in that HCAs are poised to have an increased level of significance in the nursing care workforce of the future; together with the fact that presently there are inconsistencies and lack of cohesion around the support and development of this group of staff (particularly at the start of their employment), has been provided. The role of the HCA in acute care has been reviewed in order to add further support for the focus of the research around the experiences of HCAs in an acute care hospital environment. An insight into the local picture at the NHS Trust where the research was carried has been provided in order to inform the reader in assessing the potential for the findings of this study to be applicable elsewhere. It is hopefully apparent that the research focus is *a phenomenon that seriously interests the researcher* (Van Manen 2006).

The next chapter builds on the above and appraises the literature in order to provide an overview of what is known about HCAs working in acute hospital care and in particular what is known about the experiences of those new to such a role.

2: Preliminary Literature Review

2.1. Introduction

The previous chapter has set the scene for the role of the HCA in acute hospital care and highlighted the potential significance for developments in the band 2 HCAs role for the hospital ward of the future. This chapter aims to provide a foundation for the study that follows by presenting a review of the literature on the HCA in acute hospital care with a particular emphasis on the theoretical concepts around changes in role within the context of work. .

2.2. The scope of the literature review

A literature review has been described as analysing the past to prepare for the future (Webster and Watson 2002). Its aim is to provide a critical account of the literature in a particular area in order to demonstrate why a new research study is required, to inform the proposed plan of research and to add to the understanding of the research topic as a whole (Aveyard 2014). The parameters of the literature review, in particular the depth of knowledge deemed appropriate at the start of the study, vary in accordance with the research method used, (Polit et al 2001). Research which uses the concept of hermeneutic phenomenology and an inductive approach in order to gain a deeper understanding of an experience involves interpretation of the meanings as they are experienced first-hand (Van der Zalm and Bergum 2000) is thought to be enhanced by not fully engaging with the literature in the early stages of the study, particularly prior to the analysis stage (Braun and Clarke 2006, Cresswell 2003). This is to avoid bringing bias to the interpretation of the findings (Matua & Van Der Wal 2015). Therefore, based on the chosen research philosophy and methodology of hermeneutic phenomenology (discussed in Chapter 3), the decision was taken to perform a limited literature review prior to data collection in order to inform the direction of the study but reducing the potential for bias in the analysis and interpretation of the findings. There was a conscious effort not to read the detailed discussion of study findings and the detailed presentation of conceptual models or frameworks until after the analysis stage of this research

This chapter is therefore intended to be a broad over view of key concepts and ideas rather than an in depth review of models and theories. This approach has been advocated by authors who aspire to offer a framework for understanding the topic area whilst preserving the inductive process of the research (Snelgrove 2014).

2.3. Strategy for reviewing the literature

In reality the review of the literature was an on-going process of broadening searches as the study progressed. This helped clarify the potential significance of the research, inform the practicalities of how to conduct the study and also the approach to the analysis. The literature relevant to these stages is embedded within the relevant chapters. In order to clarify how the literature was reviewed for this study, a time line of the literature searches and the reading of associated literature is included in Appendix 24.

The main themes of the literature review were:

- The HCA in the UK nursing workforce (this informed the previous chapter)
- The experiences of non- registered nursing staff as they commence a new role within an acute care environment.
- The experience of changes in role within the context of nursing
- Identification of the conceptual frameworks used to underpin the experience of role change within a nursing environment

The review centred on sourcing published evidence from the years 2005-2016 and used CINAHL, BNI, Medline and PsycINFO and focused on articles in English language that had been published in the search time frame. The ten year time frame was used in acknowledgement that the role of the HCA and that of the acute care environment are constantly evolving and therefore material produced earlier that this would likely to be of limited reference. As it was uncertain how much published work there would be, no restriction was placed on country of publication or type of health care setting at this stage. The table below indicates the key words used to identify the individual roles; the time frames and the concepts within the literature search.

2.4 The experiences of non- registered nursing staff as they commence a new role within an acute care environment- the literature.

Table 2.1. indicates the key words used to identify the individual roles; the time frames and the concepts within this literature search.

Table 2.1. Words used in the literature search

Role	Time frame	Concept
Health Care Assistant	Six months	Socialisation
HCA	First six months	Transition
Nursing Auxiliary	One year	Experiences
Care Assistant	First year	Becoming
Care worker	Twelve months	New
Health care support worker	12 months	New role
non registered nurse	First twelve months	Newly appointed
Non registered nurse		Career planning
Unlicensed nurse		Career development
Practical nurse		

This search produced 199 published citations after duplications were removed.

These were then searched by their abstracts for their relevance to the study.

Thirty two citations were discounted at this stage because they did not focus on a non- registered nursing role. An overview of the remaining 167 citations by non-registered nursing role is outlined in Table 2.2. below.

Table 2.2. Role focus of Citation:

Role	No of citations
<u>UK</u>	
Health Care Assistant/ HCA (UK)	38
Assistant Practitioner (UK)	20
Associate Nurse (UK)	5
Non registered nursing workforce in general (UK)	26
Student nurses with HCA experience (UK)	5
Care Worker (UK)	4
Healthcare support worker (UK)	2
Maternity support worker (UK)	2
Peer support worker (UK)	2
ED Technician (UK)	2
Community Nursing Assistants (UK)	3
<u>Outside UK</u>	
Practical Nurses (Canada)	12
Licensed Practice Nurses (Asia)	12

Certified Nursing Assistants (USA)	7
EN (Australia)	6
Assistants in Nursing (Sweden)	5
Nursing Assistants (Europe)	4
Nursing Aides (Asia)	3
Physicians Assistants (USA)	3
Health Care Aides (USA)	3
Palliative Nursing Assistant (USA)	2
<u>(20 Roles)</u>	167

The range of publications from which the above citations were sourced reflected the spread of the countries of publication and the number of roles identified by the search. The citations were published in forty eight journals, twenty five of which were the source of just one citation. Journals published in the UK were the largest source of citations. Of the one hundred and six citations relating to UK roles , eighty eight were published in just three journals- The British Journal of Healthcare Assistants published forty five of them, the Nursing Standard twenty nine and the Nursing Times fourteen.

Out of the 167 reviewed abstracts from the electronic search above, forty could be classed as primary research articles. Other citations focused on opinion pieces (n=25), personal reflections of experiences in a role (n=40), reviews, descriptions and discussion of role function (n=21) and training and career development (n=41). These were all read in order to give a breadth of understanding to the research question and to contextualise it within current thinking around the HCA role. It has been acknowledged (Polit et al.2001) that electronic literature searches are unlikely to identify all the relevant literature on a given topic and so additional references cited in the identified literature were sought and read for relevance.

2.4.1. HCAs in a UK acute care environment

Of the forty primary research citations, there were eleven studies from the UK that related to the non-registered nursing role in an acute care environment. The main focus of these papers was the role of the HCA in a critical or intensive care setting rather than in acute hospital care. Of these UK studies the majority (eight) focused on how members of the clinical team viewed the role of the HCA

in their clinical environment. In the main the HCA role in these situations was viewed positively although there was common theme around role ambiguity and a consensus around identifying a need for more formalised training programmes and structured support in practice.

2.4.2. Literature exploring personal experiences of HCAs in a hospital setting.

Three UK studies examined the role of the HCA in a hospital setting from the perspective of the HCAs themselves, although none of these studies involved newly appointed HCAs. However, because of the potential relevance to the experience of newly appointed HCAs in an acute care environment they will be discussed briefly here.

Workman (1996) explored the perception of eight experienced HCAs in their role as support workers to the registered nursing team in an general hospital environment using semi structured interviews and an inductive approach to analysis. This study concluded that the HCAs experienced ambiguity about their role and perceived little difference between their role and that of the Registered nurse. They also considered that the Registered nurses sometimes viewed them as a threat.

Spilsbury and Meyer (2004) aimed to understand the work of ten HCAs in one hospital through surveys, participant observation, interviews and focus groups. They identified dynamic patterns of what they termed use, non-use and misuse of HCAs in this setting which included a range of patterns of negotiation with the registered nurses throughout the working day. They also identified a need to look at the clinical competencies of these staff.

Buttler-Williams et al (2010) examined the feelings, support and feedback available to health care assistants when caring for acutely ill patients in the wards of two district general hospitals through a survey based exploration with 131 HCAs. They noted a number of stresses and emotions identified by the

HCAAs that they felt were not always recognised by the registered nursing team and they also reported limited feedback around their performance.

The studies outlined above asked different questions and produced a range of findings. They were all qualitative in nature although they chose to use differing methods to produce their findings. None of studies highlighted intended to explore the experiences of HCAAs new in post and so are limited in their potential to add to the knowledge around the experiences of HCAAs new to an acute care environment.

2.4.3. HCAAs newly appointed to a hospital setting.

A study that did aim to explore the experiences of newly appointed HCAAs, although not in acute care and not in the UK, is Peermans (2008) study of the lived experience of nursing assistants in the first 12 months of their experience in long term care in America. This qualitative study focused on factors that constituted a good or bad day; and relationships with other team members. Peerman found that key to having a good day at work was a feeling of being supported, kept in balance by staffing, working relationships and supervision and leadership. However, these findings are of limited relevance to this current study due to the fact the participants were interviewed towards the end of their first twelve months in post and the fact that the study came from a different country, a different health care system and a different clinical environment.

2.4.4. Summary of the literature review so far

To conclude this section, it can be seen that much of the literature around the non-registered nursing role is descriptive and intended to inform the reader about developments in policy and practice. It also aims to promote discussion and debate within the nursing readership of specific journals particularly around career development to new higher pay banded roles. This literature review has highlighted a paucity of literature on HCAAs in an acute care environment and very little on the experience of HCAAs new to their role. Attempting to combine these two concepts together to identify literature on the experiences of HCAAs new to acute hospital care suggests that this is an area under exposed to

nursing research in the UK. Evidence that is available indicates that fellow members of the clinical team, opportunities for learning and ambiguity around remit and responsibilities of the role are likely to influence the experiences of HCAs working in acute care in the UK.

2.5. HCAs experiencing changes in role.

Expanding the literature search to include that around HCAs experiencing change within and between roles was an attempt to identify knowledge with the potential to inform a study focusing on the experiences of individuals leaving their previous employment in order to become HCAs in acute care. Studies focusing on HCAs going through periods of change at work have looked at the experiences of those moving from health care assistant to student nurse (Brennan and McSherry 2006, Arrowsmith 2016, Lear 2016); those being seconded into nursing courses (Gould et al 2006, Wood 2006) and those moving from HCA to Assistant Practitioner role (Thurgate 2016).

Reading through this literature identified descriptive themes that were common to several studies. These were: the importance of effective mentorship and support; clinical skill development and a degree of shock when faced with the reality of the new role.

The nurse researchers conducting the above studies all used qualitative methods but differed in their execution. These studies are discussed further in the methodology chapter in order to help clarify the decisions around the choice of method for this study.

2.6. The experience of role change within the context of nursing.

In order to keep this study anchored in the world of nursing, the scope of the literature review was now widened to cover the literature on changes in role from a nursing perspective. This was justified as the writer is a nurse, this study is set within the context of nursing care and there appears to be limited literature around the experience of moving to a new role for the non-registered nursing workforce. However, it did lead to citations from non-nursing literature-

particularly sociological and psychological journals. These are referred to here when it is felt they bring background and depth to the existing knowledge around the experience of change within a work environment.

The underpinning concepts used to describe experiences in relation to role change have, for the studies reviewed so far (those focusing on non-registered nursing roles), been various and have not always been implicitly identified in the text. However, when they are acknowledged, they have tended to focus on ideas taken from two main concepts: that of Socialisation (Wood 2006, Peerman 2008) and Transition (Lear 2016) and sometimes both (Brennan and McSherry 2006).

2.7. Socialisation and Transition

A re-reading of the literature around the experiences of those moving into new roles within nursing, with the aim of identifying the underpinning ideas around role, affirmed the view that the two concepts of significance used in the literature are Socialisation and Transition. These are now briefly explored in order to give a sense of the positioning of the remainder of this study. The literature that informs the remains of this chapter is predominantly that which was read to reach this stage in the research process and is therefore largely from a nursing focus, although literature from other disciplines was also read and is included in the appropriate place in the text.

2.7.1 Socialisation

Socialisation as a concept tends to be described differently depending on the context in which it is used, the discipline defining it and the population group that it is describing. It is used to describe something that occurs over time when an individual is going through a defined change, often in a series of stages, and with a set end point (Shuval 1980, Bradby 1990). Socialisation invariably involves a change in status, often within a social structure, with the expectation that certain behaviours will change during this process. Early socialisation theorists, in particular Margaret Mead in the 1930s saw an individual's journey through life as a series of periods of socialisation (Schwartz 1980)..

Development into an adult was seen to necessitate the acquisition of cultural context and self-identification occurring as a sequence of orchestrated phases. Berger and Luckman (1967) distinguished between primary and secondary socialisation with the former concerned with development as a child and the latter with the subsequent processes a person goes through to become integrated into wider society as an adult.

2.7.1.1. Socialisation and change in role

A common theme underpinning socialisation theory is that it assumes that to go through a period of socialisation, an individual goes through a change in role. Role is concerned with status as a position in social structure with socially defined attributes and normative expectations of individual behaviour within the role, both from the individual themselves and from others (Clancy et al 2006). The socialisation processes that individuals experience in relation to their role in employment and/ or what defines them in society, form a sub section of socialisation theory. Two main concepts here are socialisation in relation to the structure and culture of the working environment- organisational socialisation and socialisation in relation to the role - occupational or professional socialisation (which are sometimes used interchangeably). These will be explored in a little more detail here as they are of relevance to this study which is focusing on HCAs in a new role.

2.7.1.1.1. Organisational Socialisation.

The key to organisational socialisation seems to be the relationship an individual has between themselves and the organisation Fisher (1985). This author, in a longitudinal study of graduate nurses in their first six months as a staff nurse defined organisational socialisation as the process by which individuals outside an organisation become fully adjusted insiders. Organisational socialisation has also been defined as a process by which newcomers acquire the social knowledge and skills they need to assume an organisational role and be accepted as organisational members (Van Maanen and Schein 1979). It is considered to take place in the first year after

employment entry when individuals begin a new relationship with an organisation (Bauer and Green 1998, Saks and Ashworth 1997). Fisher (1985) cites the work of socialisation theorists who have consistently described three key stages to occupational socialisation: firstly preparing for the change and anticipating what it will be like, secondly entering the organisation and being faced with the reality of the role and thirdly adjusting to the role by learning what to do and how to work within the culture of the organisation (Feldman 1981, Van Maanen 1975). In the nursing literature, the concept of organisational socialisation has largely been used in the study of newly graduated nurses as they commence a staff nurse role within the organisation of the hospital (Feng and Tsai 2012, Kelly and Ahern 2009, Philips et al 2015). However it has also been used in a paper that examined how student nurses fit in with the real world of practice (Houghton 2014).

2.7.1.1.2. Occupational and Professional socialisation.

Nursing studies that have explored the journey from student nurse to qualified nurse have tended to use the concepts of occupational and professional socialisation rather than organisational socialisation and key studies are outlined below. Early work used the term occupational socialisation, possibly because at the time nursing was not seen as a profession.

2.7.1.1.2.1. Occupational socialisation

Occupational socialisation is said to involve the development of identification with a specific occupation and involves shared ideologies, investment in the role and pride in what is done (Becker and Carper 1956). A key writer in the 1980s was Kath Melia (1984, 1987) whose work on the socialisation of student nurses fostered a proactive view of occupational socialisation with individuals ‘fitting in’ and ‘getting through’ and identified the challenges of needing to be both a worker and a learner.

2.7.1.1.2.2. Professional socialisation

In their review of the literature around how nurses become socialised into the nursing Howkins and Ewens (1999) focus on professional socialisation. They define this as the complex process by which a person acquires the knowledge, skills and sense of occupational identity that are characteristics of a member of

that profession. Professional socialisation has been closely linked to role identity as individuals assume an identity that is recognised by those external to the work place as well as recognising this within themselves (duToit 1995). Professional socialisation in student nurses was explored by Cohen in 1981. She made the link between how nurses were educated and their resultant professional identity. Professional socialisation was explored in many nursing studies undertaken around the time when nurse training in the UK was moving towards the higher education diploma (Project 2000) which could be seen to be striving for increased professionalism in nursing (Fitzpatrick et al 1996, Goldeberg et al 1993, Gray and Smith 1999, duToit 1995). Professional socialisation continued to be the frame of reference for many studies exploring how nurses change roles within their working life (Bisholt 2012, Price 2008). Oleson and Whittaker (1970) considered the theory underpinning professional socialisation to span the disciplines of both sociology and psychology, being based on an amalgam of the study of occupations, analysis of how individuals change, and examination of the workings of social institutions. In one of the few UK studies that have a link to non-registered staff, Brennen and McSherry (2007) used professional socialisation theory in their exploration of the experiences of eight student nurses who had at least six months experience as an HCA prior to commencing their nursing training. The American study highlighted earlier in this chapter that sought to explore the lived experiences of newly appointed nurse assistants in long term health care (Peerman 2008) chose to look at the respondents at one moment in time and used alignment between the abilities of a person and the demands or characteristics of the job, which is often referred to as 'Person-Job Fit' (Tett et al 1999) and the concept of self-efficacy (Bandura 1977, 1997) rather than a theory focusing on role change as the basis for their work.

2.7.2 Transition

The theories surrounding transition can be taken from different perspectives. Arrowsmith (2016) in her thesis on the transition to registered nurse of student nurses who were formally employed as health care assistants, differentiated

these perspectives as: centred on an anthropological perspective and the rites of passage from one stage of life to another (van Gennep (1960); centred on the world of work (Bridges 1995), and centred on the world of nursing (Meleis 2010). However this demarcation is not straightforward as there is a crossover of ideas both between and within the literature relating to each perspective.

2.7.3 Reviews on Transition in the nursing literature.

Two reviews in the nursing literature have sought to examine transition (Arrowsmith et al 2016, Kralik et al 2006). The earliest of these (Kralik et al 2006) looked at the use of transition as a term across the health literature and focused predominately on its use to explore changes in health and illness. She concluded that whilst definitions altered according to the disciplinary focus, there was a consensus that transition involves people's responses during a passage of change that entails adaptation over a period of time. Arrowsmith's focus was on work role change and transition within the context of registered nurses and as such is particularly pertinent to this study. She made the point that transition as a concept has been widely used internationally to examine how nurses move to specific roles, but that there is no systematic review of the overarching factors that nurses undergoing transition (which can occur at different stages of their working life) have in common. Transition as a concept has been used particularly widely to explore the move from student nurse to newly qualified nurse for example Cleary et al (2009), Deasey et al (2011) and Kumaran and Carney (2014); and to a lesser extent with new student nurses, for example Fagerberg and Ekman (1998) and Holland (1999). Student nurses are entering a new role in health care and it is possible that findings from these studies may have some resonance to a study seeking to explore the experiences of newly appointed HCAs. In fact the study cited in the previous section that explored the socialisation of HCAs who became student nurses, stated that its aim was to determine the 'transitional processes' associated with moving from a HCA to Student Nurse and so was linking the concepts of socialisation and transition in the one research question (Brennen and McSherry 2007).

2.7.4. The conceptual theory for this study

The preceding paragraphs illustrate how closely entwined the concepts of socialisation and transition are. Nursing as a discipline is not theoretically aligned to either concept and so, there was some freedom around the choice of reference point for this study of HCAs, and also acknowledgement that the literature from both transition and socialisation could legitimately be referred to throughout the study. The nursing literature on socialisation, which has tended to use the concept of professional socialisation to study those undergoing formal training to become a recognised professional, was felt to be of limited value in this study as the HCAs were neither undergoing formal training or working towards a recognised professional status. The concept of transition has been used widely in the nursing literature and the notion that a key component of transition is people's responses during a passage of change (Schumacher and Meleis 1994) also sat well with the aims of this study. For these reasons it was felt that the term transition had the better fit to a study looking at the experiences of newly appointed HCAs in acute care and this was the 'working conceptual term' used in the initial stages of the study.

2.8 A personal perspective.

There were times in the course of preparing this chapter that it felt as if I was looking for a needle in a hay stack. It was challenging initially to define the parameters of the literature search as the non-registered nursing role is called many things. It is possible that the wide range of terminology for the non-registered nursing role and the choice of terms for their experiences when new in post, could have limited the literature that was identified i.e. that the parameters set failed to identify some relevant publications.

It seemed that much of the literature around the role of the HCA in acute hospital care in the UK is descriptive and based on anecdotal evidence, discussion around the role within current health care climate and personal experience. I found limited literature around the role of the HCA in an acute care hospital environment and particular lack of research evidence to inform the development of strategies to support HCAs joining an Acute NHS Trust. Whilst the literature on the experience of others new to a role within nursing gives a useful foundation to this study, it is unlikely that we can assume that HCAs newly appointed to a role in acute care will have corresponding experiences. It

seems that it is likely that these individuals will have experiences that are unique to their situation and as yet unidentified.

2.9. Conclusion

In line with the philosophy underpinning the research (which is described in detail in the subsequent chapter) an in depth review of the literature on the experience of role change was not presented here. However, this chapter has brought together the identified literature relating to the role of the HCA in acute hospital care and also the literature relating to the concept of change within the world of work which helped inform initial thoughts around the theoretical focus of the study and the exact wording of the research question. There was limited literature relating to the role of the HCA in acute hospital care but significantly more around the concept of change within the world of work, however, there was relatively little combining the two to give an insight into the experiences of HCAs going through changes in role in an acute care environment. This gives credence to the uniqueness of this study and further justification for the focus of the research question. The following chapters take the reader through the research process used in the study. This begins with the next chapter which focuses on the methodological foundations of the study.

3: Research Methodology

3.1 Introduction

Previous chapters have presented the research question, highlighted the background to the study, and presented literature of relevance to the study aims. This has highlighted the significance of undertaking this study at this time and the potential for the study to offer a unique contribution to nursing knowledge.

The point has been made by Mackay (2005), that nursing knowledge development through research requires a clear rationale for the choice of methodology and that this chosen methodology needs to be coherent with both the philosophical tone of the research and the nature of the research question. This chapter addresses this through outlining the decisions behind the choice of Heideggerian phenomenology as the methodological approach to explore the lived experiences of HCAs new to a role within an acute care setting.

For clarity, research methodology (presented in this chapter), is concerned with the strategy behind the research and involves the philosophical framework and underpinning theoretical construct of the study (Denscombe 2003). In contrast the research method (presented in chapter 4), is concerned with the process and procedures that are used to carry out the research (van Manen 1990).

3.2 Research Strategy

Undertaking a research study requires a strategy that best answers the aims of the study, fits with the beliefs and values of the researcher, is achievable by the researcher and produces results that have meaning for those that are to read it. Research strategies have been described as the broader organizing features of research design (Denscombe 2003). It is acknowledged (Dyson and Brown 2006) that the choice of strategy used in a particular research activity is dependent on two interrelated components.

1. The overarching philosophical foundation
2. The ensuing methodological criteria that informs the research method

These two components of the research strategy are now discussed and form the basis of the rest of this chapter.

3.3. Philosophical foundation

There is usually more than one way to look at something and more than one way to describe what is seen. It is acknowledged that advancing knowledge through a structured line of enquiry can be done from a range of perspectives that have been termed philosophical standpoints or foundations (Dyson and Brown 2006). It is this philosophical standpoint that then informs the direction and style of knowledge seeking and the method through which this is carried out (Denscombe 2003). A set of interrelated philosophical standpoints or assumptions about the world, presented in a way that aims to provide some clarity is known as a paradigm (Kuhn, 1970).

The way in which the world is perceived, the assumptions that describe reality - known as ontology and the assumptions that underpin knowledge and truth - known as epistemology, are key determinants in framing the philosophical foundation. Somewhat simplistically, the ontological and epistemological assumptions tend to be polarised into two research paradigms with opposing philosophies. These have been viewed as two broad perspectives on the nature of reality with foundations in the positivist (scientific) and naturalistic paradigms (Polit et al 2001). The key determinate of philosophical approach is the research question that is being asked and the world view that frames this question. Research involving people, is by its very nature, influenced by those both participating and undertaking the research. This study is being undertaken by a nurse and has as its focus the experiences of a group of individuals working within a nursing environment. For this reason it is important to consider the research strategy from a nursing perspective. Nursing as an academic discipline has had a relatively short history when compared to other professions. Therefore, much of its theoretical underpinnings have evolved from other disciplines and schools of thought which have been adapted to suit nursing problems (Brink 2000 in Cohen et al 2000). The positivist approach to

research is based on the premise that there is a reality that is verifiable by observation that can be measured objectively and lends itself to a research method that is based on scientific methodology and an experimental approach where the researcher is independent from the subject of the research (Denzin and Lincoln 2000). This approach is taken by many as the foundations of quantitative research (Martin and Thompson 2000). The naturalistic approach, in comparison, takes the view that multiple socially constructed interpretations of reality exist constructed from within the experiences of individuals (Bryman 2012). It is by exploring meaning of the human condition through the subjective views and experiences of those being researched that theories are inductively generated and an understanding of the social world is reached. This approach is taken by many as the foundations of qualitative research (Creswell 2007). Most texts on nursing research choose not to focus on the underlying ontological and epistemological underpinnings and divide research into the quantitative and the qualitative to differentiate between the methods used (Jolley 2013). As this distinction is widely accepted, it is used below to highlight the thoughts behind the approach taken in this study.

3.3.1. Considering a quantitative research approach.

A quantitative research approach requires a research question that can be quantified (Martin and Thompson 2000) and aims to investigate this question by focusing on discrete and measurable aspects of an area of interest. Texts on nursing research tend to agree that quantitative research methods are underrepresented possibly through a perception that it is 'difficult' or the view that nursing is an art rather than a science (Closs and Cheater 1994, Martin and Thompson 2002).

A study looking at HCAs in their first few months in post could have taken a, quantitative approach depending on the research question being asked. At the beginning of this research journey, the idea of looking at measurable outcomes at the start of the HCAs employment and again at the end of six months was considered. It was felt that quantitative information could be used to help

evaluate the impact of the introduction of the Care Certificate that was newly introduced at the time of the start of the study. For example collecting data on learning styles and measuring knowledge and confidence against the components of the care certificate was considered. This research approach was viewed favourably by senior nursing colleagues who were keen to have succinct, quantifiable data to add to Board reports and time dependent action plans.

The literature reviewed which looked at individuals new to nursing care (which focused predominately on student nurses) illustrated limited examples of a quantitative approach. For example Worthington et al (2013) used a scale designed to quantify professional identity with over 500 Australian first year nursing students, but this approach is unusual in studies aiming to explore in depth what an experience is like for those involved.

It was important at this point to go back to the thinking behind the initial framing of the research question as outlined in previous chapters. Whilst a quantitative approach may seem a way of providing certain answers, it would give answers to a different study. It was not the aim of this study to test hypotheses, develop theory or produce replicable findings, rather to explore in detail the lived experience of selected participants at a moment in time. For these reasons it seemed that a quantitative approach was not suited to answer the aims of the research and was therefore rejected.

3.3.2. Deciding on a qualitative research approach within an interpretative paradigm.

After dismissing the potential for a quantitative approach to explore the experiences of the HCAs who would form the focus of this study, the qualitative approach, with its foundation on interpretative inquiry, was seen as the way forward. This was due to its considered potential to address the research question through focusing on the lived experiences of the study participants. The qualitative approach sits within the interpretative paradigm and takes a

subjective approach that is used to give meaning to lived experiences in order to promote understanding (Burns and Grove 1993). It aims to generate new understandings of potentially complex multidimensional human phenomena through an inductive, naturalistic approach to its participants (Denzin and Lincoln 2000) and, in contrast to the quantitative view outlined above, seeks to understand the whole (Koch 1995). The interpretative strategy often involves being exposed to the voices of others and requires an acknowledgment of the researcher's role in the study. It is the approach that was most often used in the literature which aimed to explore the experiences of nurses going through changes in role that was reviewed for this study.

Creswell (2007) identified the circumstances where the interpretive research strategy is the strategy of choice, and these resonated with this researcher.

These circumstances are:

- When a problem or issue needs to be explored
- When we need complex detailed understanding of an issue
- When the detail can only be established by talking directly to people
- When we want to empower individuals to share their stories, hear their voices
- When we want to write in a style that conveys stories without too many formal academic restrictions
- When we want to understand the context or settings in which participants address or experience an issue
- When quantitative measures do not fit the question

It has been argued that the most important outcome measure is often obtained from personal experience, which along with the experience of others can be a more powerful persuader than a high brow scientific publication in changing clinical practice (Green and Britten 1998). The potential for hearing from those actually experiencing the NHS is an advantage of an interpretative research

strategy and this sits well with the on-going emphasis on patient and public involvement in health care (Farrell 2004).

3.4 A personal perspective

The use of an interpretative paradigm to address the research question for this study resonates with my own experiences and view of the world of nursing. I became a nurse in the 1980s when the concept of primary nursing (Wright 1989) encouraged an holistic individualised framework for nursing. A research strategy that reduces participants down to discrete empirical components rather than complex interrelated ones does not sit well with my natural world view that has evolved over thirty years as a nurse.

An interpretative approach also builds on my personal experience as a novice nurse researcher who has some experience with qualitative research methods. This was through involvement in a study that involved interviewing South Asian patients to explore their experiences in the first month of recovery after a heart attack (Webster 1997, Webster et al 2002). This research revealed rich information about perceptions of illness, expectations for recovery and day to day experiences that would have been lost if recovery had been monitored as part of an empirical quantified outcome study.

3.5 Selecting an interpretative methodology

It is acknowledged that nursing faces a dilemma, in that its focus on the interpersonal aspects of health and illness lends itself to an interpretative and qualitative approach, when it is quantifiable evidence that is most often called for in order to influence policy and facilitate change in practice (Carr 1994, Martin and Thompson 2000). However, as outlined above, the interpretative approach best sits with the research question for this study and was the approach taken.

It has been said that all interpretive enquiries watch, listen, ask, record and examine (Rutty 2012). The challenge remains in determining how to execute this enquiry in practice i.e. selecting the most appropriate methodology.

The methodological opportunities available for researchers within the interpretive paradigm include (not exclusively) narrative psychology, grounded theory, discursive psychology, phenomenology and interpretative phenomenal

analysis (Creswell et al. 2006). It has been shown that using the same data with different qualitative methods generates different understandings gained from each perspective and method (Wertz et al 2011). This reinforces the importance of being clear about the underlying research strategy and philosophical foundations before deciding on the method. The research question also needs to be clear at this point and the context of the study (in this case the fact that this is a study embedded within the world of nursing) needs to be acknowledged.

Table 3.1. The link between the research question, key features of the research and the interpretative research method.

<u>Research Question</u>	<u>Key Features</u>	<u>Suitable Approach</u>
What sort of story structures do HCAs use to describe their first six months in their role?	Focus on how narrative relates to sense making	Narrative psychology
What factors influence how HCAs manage their first six months in post ?	Focus on developing an explanatory theoretical level account- factors, impacts, influences etc	Grounded Theory
How do HCAs talk about their first six months in the ward team?	Focus on interaction more than content. Caution about inferring anything about becoming an HCA	Discursive psychology
What are the main experiential features of being a newly appointed HCA?	Focus on the common structure of being an HCA as an experience	Phenomenology

Each approach within the interpretative paradigm is founded on a different set of philosophical beliefs and set within a variety of academic disciplines (Gelling 2015). Table 3.1. was put together based on the work of Smith et al (2009) who, whilst writing in depth about interpretative phenomenology, provide a comprehensive overview of phenomenology per se. The work of these authors helped decide on the most appropriate methodological approach to address the aims of the study and helped clarify certain practicalities of the method as acknowledged in the method chapter. Through linking the research question and the associated research features, it seemed that phenomenology was the approach best suited to a study that aimed to examine the lived experiences of HCAs in their first six months in post.

3.6. The philosophical foundations of phenomenology

Phenomenology is concerned with the study of phenomena. As is the nature of theories that evolve through thinking and questioning- the beliefs underpinning phenomenology are in themselves open to interpretation and described differently by different authors. Some have considered phenomenology to be a branch of psychology and philosophy (Pollit et al 2001), whereas others have viewed phenomenology as a distinct discipline (Smith 2013). A phenomenon has been described as something that is experienced, yet not understood and which is only apprehensible to us through our senses (Denscombe 2008). A Phenomenological approach considers that the discovery of knowledge cannot be attained by the empirical-analytical sciences but only by sharing common meaning of mutual history, culture and language of the world (van Manen 1990). Phenomenology is said to concern itself with the lived experience of the everyday world. van Manen (1990) refers to this as the 'lifeworld'.

Phenomenology attempts to view the world through the eyes of others in order to understand an experience as it is understood by those who are having it (Cohen 2000). In nursing, phenomenology has been described as a way in which people's everyday experiences are explored and understood (Grbich 2012, Matua and Van Der Wal 2015, Polit and Beck 2010).

3.7. Phenomenology as a methodology

Central to the challenge of linking the philosophical theory of phenomenology to the practice of research methodology is the fact that this link was never originally intended (Koch 1995). This association came later when the philosophical frameworks were used to underpin methodologies and hence research. The phenomenological research method has been described as primarily a philosophic method of question, as opposed to a method for answering, discovering or drawing determinate conclusion (van Manen 2014). Whilst reviewing the philosophy behind research that purports to use phenomenology, it did seem, as has been observed by others (Draucker 1999, Koch 1995, 1996), that published research reports have often failed to make a

clear connection between the identified philosophy and the subsequent research methodology. It has been acknowledged that there is an inherent difficulty in connecting ontologically based philosophy with the practicalities of carrying out the research (Conroy 2003, Smythe et al 2008).

3.8. Phenomenology in nursing research relevant to the research question

Phenomenology has been used extensively in nursing research as a method of inquiry that aims to explore and understand people's everyday experiences (Polit and Beck 2010, Matua and Van Der Wal 2015). It is an approach that emphasises the importance of individual accounts and so has a resonance with the holistic foundation of nursing care (Pringle et al 2011). It was a dominant approach in the research papers identified from the literature review presented in chapter 2 that focused on nurses experiencing changes in role. In these studies this philosophical standpoint was frequently justified by a desire to get to a deep understanding of an experience directly from those experiencing it (Peerman 2008). In a study (Chesser-Smith 2005) that sought to explore the lived experiences of student nurses on their first clinical placement in a hospital environment (a topic with similarities to this research study), the rationale given for choosing phenomenology was that it was felt to best represent the participants truth and give a description of their real 'life world'

3.9 Differentiating between phenomenological research approaches

This next section focuses on the theoretical basis of phenomenology and outlines the differences in how it is used as a methodological concept. Some authors have taken the way in which information is considered to be the demarcation between two main approaches to phenomenology – termed the descriptive and the interpretative (Denscombe 2008, Flood 2010, Matua and, McConnell-Henry *et al.* 2009, Polit *et al.* 2001, Van Der Wal 2015). Although some have questioned whether this distinction is genuine, postulating that it is impossible to describe something without adding interpretation at the same time (Pringle et al 2011).

Lopez and Willis (2004) comparing the philosophical components of descriptive and interpretative approaches to 'doing phenomenology', looked at how nurse researchers have used the two approaches to generate findings and then use them to augment professional practice. They summarised that the purely descriptive approach can be useful in uncovering essences of phenomena that have been incompletely conceptualised by previous research, whereas the interpretative approach is useful in examining contextual features of experiences that might have a direct relevance to practice.

Writers have distinguished between the ways in which the describer and/ or interpreter of a phenomenon recognise the impact of themselves in the process of understanding the experience. Heinonen (2015a) considered that there are two main aspects to phenomenological methodology- 'epoche' and 'reduction'. She described epoche as dealing with freeing oneself (bracketing) assumptions and reduction as dealing with returning to the original source of people's experiences. Another approach has taken the view that it is impossible to separate the researcher from assumptions and preconceptions and instead of setting aside such biases through bracketing, they are explicated and integrated into the research (de Witt and Ploeg 2006).

These different ways of approaching phenomenology are said to have their roots in the two key philosophical theories of phenomenology– Husserl's transcendental phenomenology and Heidegger's hermeneutic phenomenology (Annells 1996, McConnell et al 2009). These two theories are acknowledged to have had the most impact on nursing research methodology (Polit and Beck 2012) and will be described with particular references to their use in nursing research that is of relevance to study research question.

3.10 Husserlian Transcendental phenomenology

The mathematician Edmund Husserl (1859-1938) has been credited with founding the phenomenological approach (Polit and Beck 2004) which evolved from the works of philosophers Kant, Hegel and Brentano (Dowling 2007). This approach, which is considered to be descriptive in nature (Matua and Van Der Wal 2015), has been termed transcendental phenomenology and is said to

have introduced the study of 'lived experience 'or experiences within the life world (Koch 1995). Subsequently others shaped this philosophy into an existential approach (sometimes referred to as the French phase of phenomenology) including Gabriel Marcel (1889-1973), Jean-Paul Sartre (1905–1980) and Maurice Merleau-Ponty (1908-1961).

Husserl chose to look at the world in a way that first put aside any preconceived ideas about the way things were and what would be seen. He took a view that one needed to return to the things themselves and look at things in their own right in order to gain a true meaning. He felt that it was important to step outside everyday experience in order to be able to examine that experience and to avoid looking to fit things into pre-existing presuppositions (Smith et al 2009). In practical terms this requires one to put to one side and ignore (known as bracketing) the distractions of personal assumptions that might colour interpretations. Husserlian phenomenology is therefore built up round the idea of reduction that requires suspending the personal prejudices and attempting to reach to the core or essence through a state of pure consciousness (Smith et al 2009). Its intent is to raise awareness whilst aiming to maintain some semblance of objectivity. It has its main focus on description without an attempt to derive meaning; presenting findings prior to reflection and categorisation (McConnell-Henry 2009).

3.10. 1. Husserlian nursing research relevant to the research question

Nurse researchers have described descriptive phenomenological research that takes the approach of Husserl as focusing on the generation of knowledge that emphasises direct exploration, analysis and description of a particular human phenomenon, and in doing so, aiming to discover what it is like to undergo the experience (Matua and Van Der Wal 2015). Phenomenological description, reduction and analysis is said to lead to the unveiling and describing of general truths about the phenomenon studied (Sadala and Adorno 2002). This approach in studies looking to explore the experiences of nurses within a new work environment include that of Roziers et al (2014) who looked at the experiences of individuals moving from student nurse to community nursing in

South Africa. They justified the use of Husserlian phenomenology in order to get at a description from the participants perspective and to reduce things down to the essential structure of the experience. However they did not make clear whether any alternative approach to phenomenology was considered.

3.11. Heideggerian Hermeneutic phenomenology

Heidegger (who was originally a student of Husserl) had a primary interest in ontology or the study of being. Heidegger attempted to get at being by means of phenomenological analysis of human existence in respect to its temporal and historical character. The meaning of being was considered to be subject to the context of that being, framed by the influence of time (McConnell- Henry et al 2009). Heidegger's approach differed from Husserl in that he considered that interpreters bring their own understanding to the interpretative process, suggesting that the researcher is as much a part of the research as the participant. Heidegger argued that all descriptions are already an interpretation as understanding is an inevitable structure of our 'being in the world' (Finlay 2008). Heidegger placed particular emphasis on language as the vehicle through which the question of being can be unfolded. He was informed by historical texts, especially of those of ancient Greece, but also of Kant, Hegel, Nietzsche and Hölderlin, and to poetry, architecture and technology.

For Heidegger - phenomenology was about examining something that may be latent or disguised as it emerges into consciousness. Heidegger looked at the two parts of phenomenology and dissected them- 'phenomenon' and 'logos'. Phenomenon can be translated as to show or appear and logos as discourse, reason or judgement. At its core, this approach is about bringing reason and judgement (interpretation) as that which is being studied reveals itself. There is a focus on achieving a deeper appreciation of the experience and unveiling otherwise hidden meanings in the accounts of the experience (Matua and Van Der Wal 2015). There is a move from simply raising awareness of a phenomenon to reaching a deeper understanding of what the phenomenon

means to those who are experiencing it (McConnell- Henry et al 2009). The aim is not to gain new knowledge per se, rather to seek to interpret an existing understanding of the participant's world and through that gain increased knowledge of being in the world (Koch 1995).

3.11.1. Background of understanding

This key component of Heideggerian- phenomenology is said to come from a person's life history or background and it develops in an individual from birth (Benner & Wrubel 1989). It is this understanding that determines what counts as 'real' for the person. Heidegger (1962) considered nothing can be encountered without reference to the person's background of understanding. This framework of interpretation is known as 'pre understanding' whereby something is grasped in advance.

Heidegger (1996) suggested that our "pre-understandings" have a "forehaving" and a "foreconception" these being key to our "being-in-the-world". Forehaving is said to acknowledge that we are already in the midst of the world and its relationships even before we seek to review it (Harman 2007). Foreconception acknowledges that we are not just passively carried along unthinkingly by the world we are in, but that we always approach that which surrounds us with a specific attitude or mood (Harman 2007).

3.11.2. Hermeneutics.

Heideggerian phenomenology is sometimes described as existential phenomenology and after the work of Gadamer (1989), as philosophical hermeneutics. Hermeneutics has been described as the art of interpretation in the service of meaning with the shift to it being hermeneutic occurring when its focus and method is interpretative (Dowling 2007).

3.11.2.1. The hermeneutic circle

The hermeneutic circle is linked to the background of understanding described above. It is a metaphor for understanding and interpretation that was initially conceptualised by Heidegger and further developed through the work of

Gadamer (1976). The Hermeneutic cycle involves movement between parts (data) and whole (evolving understanding of the phenomenon), each giving meaning to the other such that understanding is circular and iterative (Ajjawi and Higgs 2007). It requires enabling pre-existing understandings to come to the fore so that appropriate questions can be asked and engaging in a dialogue that facilitates being open to the opinion of others (Annells 1996, Flood 2010, McConnell-Henry *et al.* 2009). The data is re-examined within a circle of visiting and then re-visiting the findings in order to facilitate an ever deeper understanding of the 'meaning of being' with successive interpretations (Earle 2010). The researcher remains open to questions that emerge from studying the phenomenon and allows the text to speak. Understanding therefore emerges through the process of dialogue between the individual and the text. Ideally this is a dynamic, non- linear style of thinking (Smith et al 2009).

3.12. Heideggerian Hermeneutic research relevant to the research question

Within nursing research there has been criticism of the reality of putting aside what one brings as an individual to the research process i.e. a criticism of the Husserlian view. It has been argued that the nurse is always within nursing and is not an object distinct from nursing (Benner and Wrubel 1989). Nursing research has tended to favour the Interpretative Heideggarian approach within studies that have chosen a phenomenological framework, possibly because of an intuitive acknowledgement that presuppositions and understandings cannot be put to one side.

The literature reviewed that focused on studies of nurses experiencing change in relation to work highlights several that have used hermeneutic phenomenology. For example, Farnell and Dawson (2006) in a UK study of nurses new to a role in critical care, justified the use of Heidegger's approach over Hursserl's by saying that as the researchers were experienced critical care nurses, they were able to use their previous experience to understand and interpret the participants experiences. However, several nurse researchers

have challenged the Heideggerian stance by claiming that tacit involvement of the researcher's background of understanding or preconceptions distorts the findings (Oiler 1982, Omery 1983).

3.13. Selecting the phenomenological approach

Table 3.2 below, informed through the work of Koch (1995) and Matua and VanDer Wal (2015) differentiates between the main facets of the approaches of Husserl and Heidegger (the descriptive versus the interpretative). This direct comparison helped in the final decision to use Heideggerian hermeneutics as the philosophical foundation for this study. This decision was endorsed through further reading of key texts and a personal view that previous experience and personal perceptions and understandings could not be put to one side and may in fact enrich the research process. This is expanded in the personal reflection section of this chapter.

Table 3.2. Distinguishing between main facets of the approaches of Husserl and Heidegger.

Husserl	Heidegger
Transcendental phenomenology Epistemological Epistemological questions of knowing	Philosophical hermeneutics Hermeneutic phenomenology Existential-ontological questions of experiencing and understanding
Emphasis on 'pure description'	Emphasis on 'interpretation of experience'
How do we know what we know' ?	What does it mean to be a Person?
Cartesian duality mind-body split A mechanistic view of the person Mind-body person lives in a world of objects People are 'free agents' not influenced by the environment and culture in which they live	Person as self-interpreting being Person exists as a 'being' in and of the world. Their subjective experiences are inevitably influenced by the social-cultural contexts in which they find themselves
The unit of analysis is the meaning of a given subject	The unit of analysis is the transaction between the situation and the person
What is shared is the essence of the conscious mind Starts with a reflection of mental states	What is shared is culture, history, practice, language
Meaning is unsullied by the interpreter's own normative goals or view of the world	We are already in the world in our pre-reflective selves
Participants' meanings can be reconstituted in interpretive work by insisting that data speak for themselves	Interpreters participate in making data within the fore-structure of understanding.
Claim that adequate techniques and procedures guarantee validity of interpretation Bracketing defends the validity or objectivity of the interpretation against self interest	Interpretation can only make explicit what is already understood Established criteria for trustworthiness of research is the hermeneutic circle (background, co-constitution pre-understanding)

3.14 Potential limitations of an interpretative phenomenological research methodology

Whilst this chapter has argued the case for choosing interpretative phenomenology as the methodological approach for the study, the key potential limitations of this choice need to be brought together and acknowledged. These are highlighted below.

3.14.1. Limitation of purpose and method:

The phenomenological research strategy aims to facilitate understanding and interpretation of phenomena. It is concerned with the meanings that individuals give to their experiences and aims to explore how they experience the everyday world in which they live (van Manen (1990). It is not traditionally intended to provide knowledge on how cultures or specific social groups behave or explore the reasons why individuals behave as they do.

One of the key arguments often cited against the use of phenomenology is that there is no single methodological approach for its use as a research method (van Manen 1990) which can lead to a lack of assurance around establishing validity and reliability within the method (Morse 2016). The point has been made that phenomenological studies can be time consuming to undertake and have been carried out by those who do not really understand the nature of what they are doing leading to a failure in applying the stated method in a way that is appropriate to the underlying philosophy of phenomenology (Cohen and Omery 1994, McConnell- Henry et al 2009, Norlyk and Harder 2010, Pringle et al 2009). With this in mind the decision was taken to base this study on a hermeneutic phenomenological *approach* rather than claim methodological purity and this is reflected in the personal perspective at the end of this chapter and the method outlined in Chapter 4.

3.14.2. Limitation of usefulness to practice

The importance and impact of a study has been deemed essential for a study to have value (Yardley 2000). Phenomenology as a research strategy can be unfamiliar to those who are the gate keepers for policy development. The Phenomenological approach can be seen as unscientific, unfocused, inconsequential and anecdotal to those with a background in pure science or those that require quantifiable answers (Koch 1996). It is not part of the phenomenological methodology to synthesise the findings down to accessible sound bites. It does not offer explanation of cause and effect and does not lead to generalisations that can be applied to wider practice settings (McConnell-

Henry *et al.* 2009). These factors potentially impact on the ability of phenomenological studies to influence practice.

3.15 A personal perspective.

After much reading, phenomenology was chosen as the methodology of choice, because of the central focus on lived experience which is central to the aims of the study. The concepts of reduction and bracketing were particularly difficult to grasp- the notion that you can identify what you know and understand and then somehow choose to discount it or control how it has impact on the research was counterintuitive. The interpretative approach was selected as the approach to phenomenology primarily because the literature that attempted to differentiate this approach from others, presented the case for it in such a way that it resonated with personal understandings about the nature of research. The choice of a hermeneutic phenomenological approach based on the interpretative work of Heidegger comes from a personal belief that it is impossible not to recognise presuppositions and personal characteristics when carrying out research. The concept of hermeneutic reduction seemed a misnomer initially, but the idea that I could legitimately reflect on my pre-understandings, frameworks and biases felt the right way to proceed. I have attempted to outline my initial presuppositions in the prologue to this study and aim to be transparent with my evolving thoughts and changing assumptions throughout the thesis.

Ultimately, the challenge in accepting phenomenology as the approach for this study lies in ensuring that it is applied vigorously and with transparency and that it is reported in a manner that is clear and accessible to the readership. I was a member of the local NHS Research Ethics committee for several years and have witnessed at first-hand how phenomenological research studies can be viewed with suspicion and not be understood by those used to reviewing clinical trial based research studies. I realise that my study findings may not be immediately transferable to clinical practice development and appreciate that I have a key part to play in facilitating the translation of the research findings into practice.

3.16 Conclusion

This chapter has outlined the options behind and rationale for the decision to base this study on Heideggerian Hermeneutics as the approach to phenomenology. Phenomenology is a complex concept that can be described and interpreted in different ways. A challenge for this thesis is to remain true to the key tenets of this philosophy through the practicalities of the research process. The next chapter outlines the research method.

4: Research method

4.1 Introduction

This chapter outlines how the research was carried out, being mindful of the discussion around philosophical underpinnings and methodology of Heideggerian hermeneutics presented in the previous chapter. A detailed account of the analysis stage is presented as this is considered to be pivotal to the subsequent credibility of the study. The chapter is informed through reading both phenomenological nursing research literature and studies that have research questions of relevance. This literature often referred to work from other academic disciplines, and the work of the Canadian Phenomenologist van Manen (1990, 1997, 2006, 2014), which was referenced in much of the literature, was read in detail. The work of this author was subsequently significant in informing the way in which the research was conducted after this point. The work of Ajjawi and Higgs (2007), which used hermeneutic phenomenology to study the experience of physiotherapists learning to communicate clinical reasoning, was of particular use for determining practicalities at the analysis stage.

Research methods need to be founded on robust standards of governance with clear consideration given to ethical principles (Haig 2008) and the measures taken to provide assurance around this are outlined. The chapter ends with an overview of the quality of the study based on the framework of Morse (2015).

4.2 Phenomenological underpinnings

It has been said that in order for the research method to truly reflect the chosen philosophical paradigm, there needs to be congruence between the research question, the method and the findings (Greenbank 2003, Lowes and Prowse 2001, Stubblefield & Murray 2002, Whittemore 2001). There is a need for methodological congruence and theoretical connectedness (Burns 1898). It is acknowledged that this can be a challenge as phenomenology can be viewed primarily as a philosophy (Ray 1994) or as both a research method and a philosophy (Wilkes 1991).

4.2.1. Room for flexibility within the method

Some nurse researchers consider that the phenomenological underpinnings of research should be seen as an 'approach' rather than a 'method' (Wilkes 1991) and in reality individual researchers apply the philosophy of phenomenology differently using variations in methodology. It would seem that there is more variety in the use of phenomenology as a research methodology than an overview of the philosophy might imply (Cohen 2000). Indeed it has been said that the method of phenomenology is that there is no method (Gadamer 1975). With this in mind, and in line with the phenomenological approach, the intention is to give a sound rationale for the decisions made and a clear description of what was done, in order to give transparency to the evolving understandings of the researcher and to provide assurance as to the quality of the research.

4.2.2. van Manen's influence on the study method.

van Manen took the concept of reduction, key to the work of Husserl and translated it for use within hermeneutics (Heinonen 2015a). Rather than rejecting the notion of bracketing as Heidegger did (Peters & Halcomb 2015) van Manen (1990) argued that 'bracketing' and 'reduction' have a role to play in interpretive phenomenology, supporting the belief that pre-assumptions can be incorporated successfully into interpretive research and in fact strengthen the research by being openly acknowledged (Heinonen 2015 a), Matua 2015, Sorsa *et al.* 2015, Wilson 2015). This relies on openness (van Manen 2006) in that researchers need to reflect on their pre- understandings, framework and biases (i.e. back ground of understanding) and practice a critical self-awareness (Heinonen 2015a).

Six research activities identified by van Manen (1990, 1997) have subsequently been used to guide nurse researchers undertaking phenomenological research (Heinonen 2015 a). These activities had a personal resonance. They served to provide a sense of clarity when thinking about translating phenomenology into

research method. They are listed below and are referred to within the text to illustrate where the study resonates with them.

- *Turning to a phenomenon that seriously interests us*
- *Investigating experience as it is lived rather than as we conceptualise it*
- *Reflecting on the essential themes which characterize the phenomena*
- *Describing the phenomena through the art of writing and rewriting*
- *Maintaining a strong and orientated link to the phenomenon*
- *Balancing the research context by considering parts and whole*

van Manen (2006) considered the lifeworld, which is a central concept of hermeneutical phenomenology to consist of several themes, which whilst always present, are said to dominate our experiences in different ways depending on the situation. Heinonen (2015a) attempted to summarise these themes and an outline of this is given below:

- Lived body (corporeality) - this is concerned with how we are always bodily in the world. In our physical or bodily presence we reveal and conceal things about ourselves simultaneously.
- Lived space (spatiality) -this is lived space which is 'felt' and is the space in which we find ourselves and how this makes us feel.
- Lived time (temporality) - this is our subjective time rather than clock time and the dimensions of past, present and future constitute the horizons or our temporal view.
- Lived human relations (rationality) - this is the lived human experience we maintain with others in the interpersonal space that we share.
- Lived things and technology (materiality) –these present the experience of things with regard to the phenomena being studied.

Dowling (2007), writing from a nursing perspective, condensed the above down to four themes termed modalities. These were: lived space, lived body, lived relations and lived time. She linked these four modalities back to the theory of the hermeneutic cycle and pre understanding as (she says), they acknowledge

the experience of a phenomenon in a whole experience and also the researchers role in the whole experience.

Studies that have explored the lived experience of transition within nursing using van Manen's approach include: a study of the lived journey of nurses becoming practitioners (Ogle 2007); a study of the role transition of nurses moving from a clinical ward environment to a critical care environment (Gohery and Meaney 2013); a study of the lived experience of graduate Saudi nurses (Alboliteeh 2015); a study of the experiences of bedside staff nurses who moved into roles in the pharmaceutical industry (Kavalam 2011) and a study of student nurse practitioners transitioning to employed nurse practitioners (Davis-Kennedy 2014). Some of these studies took van Manen's approach to inform the study as a whole (Alboliteeh 2015, Davis-Kennedy 2014, Ogle 2007) whilst others used van Manen as a basis for the process of the analysis (Gohery and Meaney 2013, Kavalam 2011). These studies were read in order to inform the practicalities of the method and are summarised in Appendix 1.

4.3. Research Governance.

Research governance is concerned with the way in which research is undertaken and regulated. In the UK, research governance frameworks for health and social care have been developed (Department of Health 2005). Such frameworks are endorsed by the National Institute for Health Research (NIHR) which sets out standards by which all health care research should be conducted. These frameworks encourage clear lines of clarity around responsibility and accountability in the conduct of research and provide a foundation for the consideration of the ethical underpinnings of research, being particularly concerned with the dignity, rights, safety and well-being of research participants (Hannigan and Allen 2003). It is recommended practice (NIHR 2016) for all those involved in clinical research to have training to ensure that they understand their roles and responsibilities, and in accordance with this, the researcher completed the Good Clinical Practice (GCP) training in October 2015 and the NHS Trust Consent Training in February 2015.

4.4. Study Approval.

The Trust's Assistant Chief Nurse acted as the sponsor for the study and gave her approval on April 13th 2015 (Appendix 2). The research proposal and National Health Service Research Ethics documentation, used when undertaking research in NHS settings (EMREC) was completed and ethical approval to conduct the research with NHS staff on NHS premises was obtained from the participating Trusts Research and Development office on 18th May 2015 (Appendix 3). Ethical approval was sought and gained from De Montfort University Faculty of Health and Life Sciences Ethics Committee on 18th June 2015 (Appendix 4). Participants were recruited to the study from June 20th 2015.

4.5. Practical considerations

Whilst the research question is key to the subsequent research proposal, practical considerations for this researcher undertaking the research were also of significance. These include:

- Being a lone researcher as opposed to being part of a research team
- Lack of previous experience at undertaking research using the hermeneutic approach
- Undertaking the research part time as part of an academic qualification
- Undertaking the research whilst experiencing the challenges of a full time job and the demands that day to day life brings.
- Lack of research funding to support the research
- Being limited in terms of time to complete the research
- The word limit for the thesis
- Having expectations from line managers around the nature of the research.

4.6. Choice of research method

It was important to be aware of the limitations of the research method chosen and to be mindful of compromises made for practical reasons. For this reason it is worth briefly outlining how others have approached research that has looked at how health care workers experience new roles from a phenomenological perspective in order to justify why these methods were not used for this study. This is summarised in Table 4.1. and is informed by the literature (Bradbury-Jones et al 2009, Stokes and Bergin 2006, Mayou and Onwuegbuzie 2013).

Table 4.1. Mixed methods and Focus groups. Two-methods used in phenomenological nursing research exploring the experience of new roles that were not used in this study.

Method	Examples in nursing research that looked at movement into a new role.	How the method was executed in the study examples.	Potential benefits of a mixed method approach.	Why this method was rejected as an option for THIS study.
Mixed Methods	<p>Alboliteeh (2015).</p> <p>Choosing to become a nurse in Saudi Arabia. The Lived Experience of new graduates. A mixed method study.</p> <p>.....</p> <p>Day et al (2005)</p> <p>Exploration of student nurses evolving beliefs about nursing as they progress through a four year degree programme</p>	<p>Self Administered Questionnaires to whole cohort</p> <p>In depth interviews for 12 nurses</p> <p>.....</p> <p>Open ended questionnaires to 50 students and face to face interviews with 12</p>	<p>Ability to triangulate findings- potentially more reliable findings.</p> <p>Larger numbers given the questionnaire may produce findings more representative of the population being studied</p> <p>Quantitative results may have more immediacy for feedback to practice</p>	<p>Takes more resources and time which were both limited for this study.</p> <p>Potentially over onerous and confusing for participants.</p> <p>Relying on alternative methods detracts from a belief that phenomenology is the best way to explore lived experiences – confusion of paradigms .</p>

Method	Examples in nursing research that looked at movement into a new role.	How the method was executed in the study examples.	Potential benefits of using focus groups.	Why this method was rejected as an option for THIS study.
Focus groups	<p>Jasper (1996)</p> <p>The experiences of project 2000 nurses in their first year</p> <p>-----</p> <p>O Brian et al (2008).</p> <p>Exploring non- mature general nursing students perception of nursing just before their first clinical placement</p>	<p>Focus group discussion with 8 participants</p> <p>-----</p> <p>Focus groups x4 with 23 participants</p>	<p>Takes less time. May encourage reticent speakers to speak up</p>	<p>More complicated to organise. Takes researcher skills to manage the group interview</p> <p>The HCAs did not know each other and may have felt inhibited to share experiences</p> <p>May not get the true experiences from Individuals- peer pressure, desire not to appear different Does not sit with phenomenology.</p> <p>(Webb and Kevern 2000).</p>

The final research proposal was developed after taking all of the above into account. Salient parts of this will be discussed and expanded upon throughout the remains of this chapter.

4.7. Capturing the experiences of the HCAs in the study.

The experiences of the HCAs in the study were captured through the process outlined below, with subsequent rationale and clarification.

- Demographic questionnaires were used to determine the background of a cohort of HCAs (N= 40) newly appointed into post. Information collected included age, gender, previous experience with caring and current place of work within the Trust.
- Twelve HCAs from the cohort were purposefully selected to take part in the study.
- Semi structured in-depth interviews were carried out in the first three/ four weeks of appointment and again at six months in post, in order to explore, from a phenomenological perspective, lived experience at these two moments in time. The direction of the interviews was informed by the aims of the study.

4.7.1. Demographic Information

It was considered important to be aware of certain demographic information about the participants of the study. This was in order to have an awareness of how the participants compared with their peers from within the cohort of HCAs recruited to the Trust in May 2015. It was also interesting to see how the sample compared to the HCAs employed by the trust as a whole. Therefore, even though the method was qualitative in nature, quantifiable information was collected on age, gender, previous experience working as a carer and the clinical area within the Acute Trust where the individual was going to work. This short questionnaire (Appendix 9) was given out to all the cohort of newly appointed HCAs (N=40) who commenced employment at the start of the study.

The questionnaire was given out as part of the first taught induction day during the HCAs first week in post. It was given out by members of the education and practice development team who were aware of the nature and purpose of the research in case there were any questions asked, but were not involved in the study itself. It was made clear that the information collected would be treated with sensitivity, that completion of the questionnaire was not compulsory and that identifiable information was only necessary if respondents were interested in taking part in the interview part of the study. To this end, the last page of the

questionnaire had a reply slip where individuals could give their contact details if they were interested in finding out more information about taking part in the main study.

4.7.2 The Interviews.

The decision was made to conduct semi structured interviews with participants. The main aim was to understand the areas of importance to the participants *and investigate the experience as it is lived rather than as we conceptualise it* (van Manen 2006). Semi structured interviews are seen as enabling a conversational relationship with the participant about the meaning of the experience whilst retaining some scope for questions to be modified in the light of the participants' responses (Ajjawi and Higgs 2007). The aim is to avoid leading the participant to specific answers (Crotty 1996), whilst being able to probe interesting and important areas which arise, thereby offering a balance between flexibility and control whilst giving reassurance that the aims of the study can be achieved (Flood 2010). It has been said (Lowes and Prowse 2001) that the phenomenological research interview is a purposeful data-generating activity, characterized and defined by the particular philosophical position adopted by the researcher. The interview in this study was reflective in order that the participant's descriptions could be explored, illuminated and probed in order to reach their lived experiences (Jasper 1996, Kvale 1996, Walker 2011, Wimpenny and Gass 2000). Morse and Field (1996) promote the semi-structured interview technique as being useful because it ensures that the researcher obtains the information required, while giving participants the freedom to explain a situation in their own words. This is in keeping with van Manen's (1997) view that the role of the researcher in the hermeneutic interview is to keep the interviewee focused on the topic being investigated, with the interviewer able to control for and ensure similarity between the interview situations (Opdenakker 2006). This style of interview is an approach with which the author of this thesis has some experience (Webster 1997, Webster et al 2002). With this method there is no significant time delay between question and answer and both participants (the interviewer and interviewee) are able to

respond directly to what the other says (Opdenakker 2006). A word of caution has been provided by Wimpenny and Gass (2000), who are mindful of potential inconsistencies in interview approach by researchers purporting to be using a hermeneutic phenomenological methodology. They identified a challenge around having an openness of interview deemed to be required in phenomenological interviewing versus the need to have some structure to the interview. This was borne in mind when preparing and conducting the interviews as outlined below.

4.7.3. The Interview questions

A set of questions were produced before the interviews to focus the interaction around the research question and to allow the wording of questions and sensitive topics to be thought through (van Manen 1997). Thinking in advance about the different ways the interview may unfold is said to allow the interviewer to concentrate more thoroughly and more confidently on what the respondent is actually saying in order to get closer to what the respondent thinks about the topic without being led too much by the questions (Smith et al 2009). The interview schedules used for this study are outlined in Appendix 11 and 12. The questions were organised under a list of broad topic headings which served to attempt to keep the conversation focused (Hansen 2006). In common with other researchers using phenomenology, each interview started with a broad descriptive question intended to place the interview in the context of the participant's lived experience (Spradley 1979). As advocated by other researchers (Walker 2011), participants were asked questions that began with: 'Tell me about ...; and then if necessary probed further with questions that began 'In what way?'; 'what was that experience like for you?' and 'how did you feel about this? Probing was used in a way that was mindful of the fact that it is an interviewing skill that needs to be handled sensitively (Fielding and Thomas 2001) as it can make participants feel uncomfortable and may lead to bias if the conversation becomes too guided.

4.7.4. Time frames and the number of interviews

The six month time frame for the carrying out the two interviews was considered long enough for the participants to have experienced a significant period of time in their new role whilst being practically manageable in terms of getting the study done. The participants were interviewed on two occasions, at 3-4 weeks and again after six months in post. Writers have approached the study of experiences over time in different ways. It would have been feasible to interview two separate groups at the two study points. However, it was felt that this method would fail to capture the thread of experience of one group of individuals over time. Conducting interviews on one occasion at the end of the study period has been used when the time frame is relatively short, for example nurses on one particular clinical placement (Chesser- Smythe 2005). Gould et al (2006) in a study exploring the experiences of HCAs who had been seconded to do their nurse training, interviewed participants once as they became staff nurses. One of the few studies exploring the lived experiences of recently appointed HCAs (Peerman 2008) which focused on nursing assistants appointed to roles in long term health care in America, interviewed the ten participants once towards the end of their first year post. This approach potentially loses the vivid recollections of the initial experiences. In contrast, and in common with this study, other researchers looking at experiences over time, have conducted more than one interview with each participant, claiming that this reflects the fact that time is an essential element in the experience (Kralik et al 2006), and that it gives a more honest reflection of their experience (Smith et al 2004). The majority of studies reviewed that explored the experience of student nurses new to their role conducted at least two interviews, often spaced out over time, and therefore having focus on the participants experiences over a period of time. (Brown 2004, Day et al 2005, Flaming 2005, Farnell and Dawson 2006) and this was the approach taken for this study. .

4.7.4.1. The first and second interview.

When more than one interview is used, researchers have differed in the way in which they formulate the interview schedules. There is the possibility of using a first interview as a prompt for further discussion at a subsequent interview (Flowers 2008) or for using the second interview as an extension of the interpretative process by digging more deeply (Snelgrove 2014). Whilst the second interview went over similar ground to the first (see Appendix 11 and Appendix 12), it was not the intention to use the first interview to inform the first and each interview was taken as a discrete event and initially analysed independently. Each interview was seen as part of the whole experience and the participants were not specifically asked to focus on the six month period as a whole. This is an approach that fits with Heidegger's (1927/1962) concept that time and spaces are unique to the given situation (McConnell-Henry et al, 2011).

4.7.5. The interview setting.

The participants were given choice as to where and when the interviews took place although it was decided for logistical reasons that all the interviews would be carried out on Trust property at a time when the HCAs were at work. The participant was informed at least a week in advance about the interview and provisional arrangements were made for the date, time and location of the interview that best suited them. Interviews were conducted in the evenings, early mornings and at weekends as well as during 'office' hours. On a few occasions due to shift changes or sickness this had to be changed. The participants were given a work mobile phone contact number to contact the researcher. The HCAs ward manager was informed of the interview details and was always spoken to prior to the interview to make certain that they felt that it was appropriate for the interview to still go ahead. Several of the interviews took place in a quiet room on the ward, and others in an empty office or a quiet seminar room away from the ward area.

It is known that the setting of the interview can have an impact on the research findings. For example Walker (2011) conducted interviews involving health workers in their place of work and concluded that this brought the discussion 'alive' and made it easier to contextualise the participants' descriptions during the process of transcription. Personal experience of conducting interviews with partners of patients after a heart attack (Thompson et al 1995) found that participants were more open, and the interviews longer when the interviews were conducted in the home as opposed to in the hospital.

The length of time for the interview varied between participants. Hansen (2006) suggested that a semi-structured interview should run for between 60 and 90 minutes and all the interviews fell within this time frame. For all interviews a 'Do not disturb' sign was placed on the interview room door. These measures helped ensure that all the interviews proceeded without interruption.

4.7.6. Audio recording the interviews

An audio recorder was used with the participant's permission for the purpose of capturing the exact words of the interview as accurately as possible. This recording device used was a small portable digital recorder with a built-in microphone and over three hours of recording time. This meant that participants were free to talk without the interruption of cassette tapes being changed. Notes were not taken during the interview. This is said to help avoid distraction for the participant and to make it easier to concentrate on what is being said Rabionet (2011). However notes were made after each interview to capture anything said off tape and to contextualise elements of the interview during data analysis.

4.7.7. Transcription.

The audiotapes were personally transcribed within a week of each interview. Administration support was not sought at this stage as it was felt that the immersion in the interviews required for transcription would help initiate the in depth understanding required for the analysis (Englander 2012).

4.7.8. Keeping a Research Notebook.

A research notebook was used throughout the study to:

- record thoughts, personal reflections and ideas
- record research activities, supervisory sessions, personal impressions, reactions and document progress
- note ideas from reading and the particular information that was learnt
- highlight things to do and things to go back to

Keeping the note book encouraged a reflexive approach to the research process that is accepted by many researchers as being intrinsic to the research process itself (Ortlipp 2008). Regular writing helped to highlight presuppositions, choices, key experiences, and decisions made during the research process. Insights from the research notebook were used throughout the writing up stage to give transparency and a personal perspective to development of the study. This sits well with the underlying foundation of hermeneutic phenomenology which is central to this study.

4.7.9. Pilot Interviews.

Two interviews were undertaken by the researcher before the study interviews commenced to act as a rehearsal or pilot for the main study interviews. The aim was to test out the interview schedule, the style of the interview, the nature of the responses given and for the participants (including the researcher) to have the opportunity to critically review the experience of the interview. It was also an opportunity to test the audio recording equipment. The aim was to maximise the potential for the research interview to gain information of relevance to the research question. It is known that the participant, the research tool and the interviewer all have a bearing on this (Flick, 2007). It is also acknowledged that phenomenological interviews require particular skill on the part of the interviewer as they aim to get to the 'thing itself' rather than just facts and opinions (Benner 1994).

The rehearsal interviews involved two HCAs who had been recruited to the trust six months previously and who volunteered to take part. These interviews did not form part of the main study. The two HCAs were asked for feedback around the length of time the interview took, their understanding of the questions, the style of questioning and the ease with which they felt able to share their experiences. The responses were reviewed to see if they reflected the intention of the questions. This process was a good rehearsal for the researcher in conducting the interviews, particularly in how to introduce the study and explain the interview process, but did not lead to any alteration in the interview format or questions.

4.8. Ethical Issues

The researcher is a nurse and the research was conducted on NHS property involving NHS staff. It was also being conducted through an academic institution. The study therefore needed to meet the ethical requirements of both organisations involved and be mindful of the professional code of conduct of the researcher (NMC 2015). Many of the issues such as informed consent, the dignity and privacy of the research subjects, voluntary participation and protection from harm have their basis in moral and ethical principles and are the same in qualitative research as in other types of research (Allmark et al 2009). However, it has been argued that qualitative research generates specific ethical problems because of the close relationship that researchers potentially form with participants (Holloway and Wheeler 1995).

The key ethical requirements can be summarised by the three points below which were considered at all stages of the study.

- Respect for autonomy, particularly around voluntary participation and informed consent.
- Causing no harm
- Anonymity and confidentiality, particularly around the storage of data and presentation of findings.

The ethical considerations for this study and how these were addressed are outlined in Appendix 10. The participant information sheet and the participant consent form are reproduced in Appendix 6 and Appendix 7.

4.8.1. Ethical considerations when conducting interviews.

All the interviews were conducted in privacy with only the researcher and the participant present in the room. It was made clear to the participants both prior to the study and at the time of the interview that the conversation could stop at any time and that not all questions asked needed to be answered. In a review of the ethical issues implicit in conducting in-depth interviews (Allmark et al 2009) concluded that privacy was a significant problem as interviews sometimes explore areas that were not envisaged in the participant information. These reviewers also highlighted that full informed consent is difficult as the true nature of a particular interview is not known at the outset.

4.8.1.2. The researcher- participant relationship.

It has been acknowledged that the hierarchical difference between the researcher and the participant, sometimes referred to as a potential power differential, can have an impact on the research interview (Holloway and Wheeler 1995, Richards 2002). This needed to be acknowledged and any potential negative implications for the study minimized (Allmark et al 2009). The HCAs in this study were new in post and were being interviewed by a researcher in a significantly higher position in the organization. This could potentially have made them reticent to speak freely about their experiences through, for example, a conception that what they said would impact negatively on their induction experience and career prospects. Care was therefore taken to clearly explain the remit of the study and the researchers role in it, with a particular emphasis on confidentiality and anonymity. The researcher was not involved in the delivery of the HCAs induction programme, but the study participants had all been exposed to nurses from the education and practice development team over the course of their eleven day induction programme and hopefully felt familiar and comfortable with someone in this role. The participants were all at work at the time of the interview and so were wearing

the grey uniform of the HCA. The majority of the interviews took place within the normal working hours of the researcher and so, for convenience and consistency, the researcher conducted the interviews wearing the royal blue nursing uniform worn by members of the nurse education team. This potentially reinforced the study as being a 'nursing' one' and possibly gave it a practical nursing focus (rather than an academic non-nursing one), in the eyes of the participants.

4. 9. The research sample.

A purposeful selection method was chosen, as recommended by several authors for this type of research, in order to select information-rich cases for detailed study (Denzin and Lincoln, 2000; Patton, 2002). Therefore, as advocated by Morse (2015), participants were selected who were the most likely to be able answer the research question. They were those who were able to provide access to a particular perspective and for whom the research question would be meaningful (Smith et al 2009). Sampling implies that a researcher is choosing informants because those informants might have something to say about an experience that they share with others. They are people who offer a picture of what it is like to be themselves as they make sense of an important experience (Steeves 2000).

The sample available for inclusion for this study was:

- Those who had commenced employment in the Trust to work as an HCA within the previous four weeks.
- Those who had not worked in an acute hospital environment previously
- Those who completed the demographic questionnaire; returned the expression of interest reply slip and agreed to take part in the study.

4.9.1. The sample size.

The final study sample consisted of all twelve HCAs newly appointed to an acute hospital trust who met the selection criteria (new to acute hospital care)

and expressed an interest in taking part by returning a reply slip. These individuals formally consented to participate in writing after being given the participant information sheet to read (Appendix 6) and having the opportunity to ask further questions. Whilst it has been said that there is no right answer to the question of sample size in phenomenological research (Smith et al 2009), others have attempted to give some guidance by saying that the scientifically important criterion for determining sample size for hermeneutic phenomenological researchers is the intensity of the contact needed to gather sufficient data regarding the experience (Steeves 2000). A sample that is too small can produce results that are superficial and obvious plus there is potential for limited variation with findings that are limited in scope (Morse 2015). A large sample size may be difficult to manage with resulting compromises on quality and robustness in applying the research method (Smith et al 2009). Practical considerations, including the time needed to recruit participants and to arrange the interviews; the time taken to conduct each interview and to transcribe the tape recordings and analyse each interview were considered. The phenomenological research literature reviewed up to this point was re-read in order to determine the sample size used in studies that had relevance to this studies research question and context. The sample size of twelve is in line with that of similar studies and was considered acceptable for this study.

4.10. Analysis.

4.10.1 Aims of the analysis.

It has been said (Morse1994), that all qualitative research involves a process of analysis that requires the researcher's cognitive processes to interact with the data in order to generate findings and produce new knowledge. The goal of analysis in Hermeneutic phenomenological research is said to be a thick description that accurately captures, and communicates to others, the meaning of the lived experience in all its richness and complexity of the informants who have been studied (Cohen et al 2000, Sandelowski 1995). Many qualitative researchers have concluded that systematic, rigorous and auditable analytical processes are among the most significant factors that distinguish good quality

research from bad (Thorne 2000). However, there appears to be a challenge in condensing the ‘ Art ‘ of phenomenological enquiry into a linear step by step activity that can be adequately described to others (Flood 2000). Indeed the concept of “analysis” itself has some challenging implications for a phenomenological standpoint in that the term usually means “breaking into parts” and therefore, as has been said (Crist and Tanner 2003) analysis has the potential to dilute or even lose the concept of a whole phenomenon.

4.10.2. The process of analysis.

It has been argued (Smith et al 2009), that the existing literature on phenomenology has not prescribed a single method for working with the data. This may in part be due to the fact that some researchers take the view that hermeneutic analysis does not require a step by step method or analytic requirement and quite rightly avoids method for method’s sake (Kalfe 2009) relying on an openness to the thinking that emerges with an offering of interpretation that enables other to engage with the learning (Smythe et al 2008).

However, some structure was needed to get the analysis done. Morse (1994) believes that all qualitative analysis, regardless of the specific approach, involves:

- *Comprehending* the phenomenon under study
- *Synthesising* a portrait of the phenomenon that accounts for relations and linkages within its aspects
- *Theorising* about how and why these relations appear as they do, and
- *Recontextualising*, or putting the new knowledge about phenomena and relations back into the context of how others have articulated the evolving knowledge.

As the study sits within the discipline of nursing, the analysis was informed in the main by nursing texts, nursing journal articles and published nursing research studies. Examples of nursing research articles that were identified in the literature searches around ‘ becoming a HCA and ‘transitions in nursing’ that used a phenomenological approach, in particular Heideggarian hermeneutics, were re-read to determine the rationale for and process of data

analysis. In addition, a further literature search specifically for nursing publications that purported the use of Hermeneutical phenomenology was undertaken and again these papers were read in order to inform the analytical approach. This highlighted that a range of approaches have been used for analysis in hermeneutic phenomenological methods. For example, Alboliteeh (1995) in a doctoral thesis of a hermeneutic phenomenological study of the lived experiences of graduate nurses in their transition to the staff nurse role, gave an account of the use of the analytical approach used by van Manen (1990). Peerman (2008) in a doctoral thesis exploring the lived experiences of recently appointed certified nursing assistants in their first year in a role in a residential long term care nursing home in America described using Giorgi and Giorgis (2003) descriptive phenomenological analysis. It would seem that the analytical method can be chosen for practical reasons rather than scientific or philosophical ones. For example Chesser–Smyth (2005) in a paper reporting on a phenomenological approach to exploring the lived experiences of student nurses in their first year of clinical placement admitted that Coliazzis (1976) seven stage framework of analysis was selected because it seemed the most straightforward to follow rather than for any theoretical reason.

Whilst many authors have used ‘variations on a theme’ to analyse interviews under the umbrella of phenomenological research, such analysis can be characterised by similar key processes. The method which seemed to best fit with the study and with the approach to it, whilst meeting the requirements of the methodology, is the one outlined by Ajjawa and Higgs (2007). This is summarised below in Table 4.2. It was a framework that seemed manageable in light of the number of transcripts that needed analysing and the time frame of the study. It is therefore this framework which best represents the analytical activities used in this study, although the wide reading that was carried out to get to this point influenced the finer details of how each part of the process was executed. In particular the work of van Manen, which is highlighted throughout this chapter, is referenced where it has had influence.

Table 4.2 Stages of Data Analysis informed by Ajjawi and Higgs (2007) and van Manen (1997,2006)

STAGE of Analysis	Task as identified by Ajjawi and Higgs (and van Manen)	Personal interpretation of the method
Immersion	<ul style="list-style-type: none"> Organizing the data-set into texts Iterative reading of texts Preliminary interpretation of texts to facilitate coding <p><i>Unorganised and unrestricted coding, in line with van Manen's selective or highlighting ' approach (van Manen 1997).</i></p>	<p>-Interviews transcribed and resulting transcripts treated independently- read through several times, with notes and reflexive comments made.</p> <p>-Identification and highlighting of key words, phrases and metaphors within the transcripts- compared across transcripts. Rewriting interviews in the third person</p>
Understanding	<ul style="list-style-type: none"> Identifying first order (participant) constructs Coding of data using NVivo software <p><i>Identifying the things of our experience (van Manen 1984).</i></p>	<p>-Reflection on initial codes & key words.</p> <p>-Ongoing review of audio tapes and interview transcripts. Re working the themes- different manifestations of existing themes and new themes. -.</p> <p>-Formation of descriptive themes.</p>
Abstraction	<ul style="list-style-type: none"> Identifying second order (researcher) constructs-interpretation Grouping second order constructs into sub-themes <p><i>The distinction between the things of our experience and that which grounds our experience (van Manen 1990)</i></p>	<p>-Relating back and linking descriptive codes to quotes in text, using a iterative process for interpretation</p>

STAGE of Analysis	Task as identified by Ajjawi and Higgs (and van Manen)	Personal interpretation of the method
Synthesis and Theme Development	<ul style="list-style-type: none"> • Grouping sub-themes into themes • Further elaboration of themes • Comparing themes across and between sub-discipline group <p><i>Maintaining a strong and orientated link to the phenomenon (van Manen 2006).</i></p>	<ul style="list-style-type: none"> - Identification of potential links and connections within and between the interviews and identifying emerging interpretative themes in each transcript. - Repeating this process several times- -Connection of sub themes from the texts into key interpretative themes, with related contextual significance- -Returning to the data for re-examination of themes emerging, diminishing and evolving across the two interviews i.e. comparing the parts and the whole.
Illumination and illustration of phenomena	<ul style="list-style-type: none"> • Linking the literature to the themes identified above • Reconstructing interpretations into a framework <p><i>Describing the phenomena through the art of writing and rewriting (van Manen 2006).</i></p>	<ul style="list-style-type: none"> -Production of a detailed, interpretative, reflexive written account for each set of interviews.
Integration and critique	<ul style="list-style-type: none"> • Critique of the themes by the researcher • Reporting final interpretation of the research findings 	<p>Overarching concepts identified from the main findings of the study linked to existing knowledge in order suggest a new framework for the lived experience over six months.</p> <p>-summary and conclusions with limitations of the study acknowledged and recommendations made</p>

4.10.2.1. Immersion

Repeated re reading of each interview; reading the interviews in reverse order, writing up a summary of each interview in order to examine the flow of individual participant experience and the inter-relationship of individual experiences with the experiences of others, all facilitated the initial immersion. Key words, phrases and metaphors within and between the transcripts were identified in a process of unorganised and unrestricted coding, in line with what van Manen terms a 'selective or highlighting' approach (van Manen 1990). Lindseth and Norberg (2004) referred to this as naive reading whereby the text is read several times to grasp its meanings. They stated that the researcher needs to be 'open' so the text can talk to them and provide a naive understanding. Cohen et al (2000), considered that the reader begins with a vague and tentative notion of the meaning of the whole of the data and then reads through the data several times or more. This is in order to immerse fully in the data and to begin to identify the essential characteristics in the data for each interview. This was an attempt to move from the emic-implicit meaning of the participants to the etic-explicit meaning of the researcher (De Santis and Ugarriza 2000, Giorgi 2009).

4.10.2.2. Description and Understanding

The analysis involved on-going reflection on initial codes and key words together with on- going review of audio tapes and interview transcripts. The initial codes were re worked and examined to produce different manifestations of existing codes and the formation of descriptive themes. Hermeneutic science is said to involve the art of reading a text in order that the intension and meaning behind appearances are fully understood in order to arrive at a conscious description of an experience (Moustakas1994). Other authors have called this the appearance of the experience (Conroy 2003) or the things of our experience (van Manen 1984) and it involves reflecting on the essential themes which characterize the phenomena (van Manen 2006).

4.10.2.2 1. Moving back and forth

A consistent view of those writing about the analysis of hermeneutic phenomenological research is that the process is NOT linear, although it is

usually described in a linear fashion (Cohen et al 2000). Smythe et al 2007 described the analysis as involving lots of backwards and forwards reflexivity between thinking and writing and reading activities. They pointed out that the thinking goes in lots of different directions with analysis codes changing throughout the analysis (Corbin and Morse 2003). Those codes identified early in the reading of transcripts were not those that developed after re-reading several times. This fits with the concept of the Hermeneutic cycle (Gadamer 1989) i.e. the moving between the whole and the parts which is a fundamental concept in the underlying philosophical framework of this study.

4.10.2.3. Interpretation – abstraction leading to synthesis and interpretative theme development

This involved relating back and linking descriptive codes, using an iterative process for interpretation and identifying potential links and connections within and between the interviews and the development of sub themes with related contextual significance. Smythe et al (2007) considered that in hermeneutic phenomenology, themes are not in themselves a finding stripped out of the data, but a way to show what we see or hear in a text i.e. they are the result of interpretation. Themes have been seen as a way of fixing examples in order to bring them to reflexive understanding (van Manen 1990). Langridge (2007) suggested that this stage is about uncovering the essence buried within the anecdotal level of the text. Throughout, the aim was to create interpretive themes that remained strongly linked to the data and in so doing allow for the emergence of concepts beyond the specific questions that were asked of the participants (van Manen 1990). To enhance this, the creation of themes was informed by the lay language of the participants rather than from any preconceived theoretical construct. The aim was to have a relationship between the direct conscious description of an experience and the underlying dynamics or structures that account for that experience (Moustakas 1994). There needed to be a shift from the appearance to the essence and from knowing that to knowing how (Conroy 2003). This has been described by van Manen (1984) as

the distinction between the things of our experience and that which grounds our experience.

4.10.2.4. Acknowledging the part played by the researcher

It is acknowledged that in hermeneutic research analysis, the analysis moves away from representing what the participant says to become more reliant on the interpretive work of the researcher (Smith et al 2009). Lopez and Willis (2004) considered that a Hermeneutical approach produces meanings arrived at as a result of a blend of the meanings articulated by both participant and researcher within the focus of the study. It has been said (Cohen et al 2000) that the researcher cannot but help start to analyse and interpret the meaning of what the words spoken right from the start of the first interview when they are actively listening and thinking about what is being said. Personal experience with this study involving HCAs supports the view that an attempt to make sense of the data does indeed begin whilst the interviews are in progress. This needs to be recognised together with an acknowledgement of the discipline required to not 'jump to conclusions' too soon in the data collection phase of the research (Sandelowski 1995). This relates back to the concept of preconceptions in hermeneutical research. The background of the researcher and the initial thoughts highlighted in the prologue to this study need to be acknowledged.

4.10.2.5. Member checking

Asking participants to validate their interviews by checking the transcripts for accuracy (member checking) has been said (Guba and Lincoln 1989) to be the most important factor in giving a study credibility. However, as each interview was unique to time and place, it could be argued that asking participants to validate what they have said months before goes against the underlying philosophy of the study and Heidegger's emphasis on revealing 'what is' at a particular moment in time (McConnell- Henry et al 2011, Smith et al 2009, Webb 2003). This uniqueness of time was illustrated in this study through an occasion when the tape recorder failed to record and the interview carried out a day later revealed different experiences to the first. All the transcripts were given to a colleague to check for accuracy against the tape recordings.

In hermeneutic phenomenology, the final interpretation is personal to the individual making the interpretation (in this case the researcher). For this reason the participants were not involved in any of the analysis stage and the interpretation was ultimately the work of one individual rather than a collaborative process. The researcher is said to have a significant participatory role in making the data (Koch 1995). Crotty (1996) made the point that each person involved in the analysis and interpretation must engage in phenomenological seeing in relation to her or his own experience and that , whilst others can be involved and offer guidance and challenge assumptions, they cannot do the phenomenological research on another's behalf. There was no peer review of the analysis stage of this study, although it is acknowledged that further insight can be gleaned through challenge and discussion with those who are more experienced (McConnell- Henry et al 2011). Samples of the interviews were shared as part of the supervisory process and discussion of the emerging themes at supervisory sessions helped to crystallise the findings and ensure that there was transparency behind the interpretation.

4.10.2.6. Use of computer software to aid the analysis

The transcriptions produced a large amount of material which initially seemed daunting to manage as a data set. In order to facilitate the analysis process and to help ensure that emerging themes were not overlooked, the QSR NVivo 11 for Windows software package was used to help sort and organise the data. In the initial stages of the analysis (immersion), key words and phrases considered to be particularly insightful were highlighted electronically. It was easier and quicker to code text on screen than it would have been to manually cut and paste different pieces of text relevant to a single code onto pieces of paper to be then stored in a file. The computer software also made it more straightforward to return to the text and find quotes from within the transcripts and in the end the computer software was largely used as organizing tools which is in common with other qualitative researchers (Smith and Hesse-Biber 1996). It is well recognised that computer programmes are not capable of the intellectual and conceptualising processes required to transform data into

meaningful findings (Welsh 2002). Whilst NVivo has the potential to improve the rigor of the analysis by giving a transparency to the researcher's own impressions of the data (Bazeley and Jackson 2013), it has been found less useful in terms of addressing issues of validity and reliability in the way that thematic ideas emerge (Thorne 2000). In reality the themes emerged by much reading, re reading and cross referencing of the typed up interviews with much of the analysis undertaken from returning to hard copies of the transcripts. This sits with the idea of the hermeneutic cycle with a movement between parts (data) and the whole (evolving understanding of the phenomenon) in order to develop understanding in a circular and iterative manner (Ajjawi and Higgs 2007).

4.11. A personal perspective.

It seems approaches to analysing phenomenological data are formed and evolve through an individual's experience of 'doing'. Those in a position to write authoritative texts on the subject do so from a standpoint of many years of practical experience. This means that a novice researcher, such as myself, has to take a leap of faith and hang on to the coat tails of those more experienced researchers who give the best guidance. It is therefore quite likely that if this research study were to be repeated, the analytical method selected would change as a result of learning through doing.

4.12. Strategies for quality assurance.

This chapter has been written in a way that highlights the choices faced and decisions made as the research process developed. This was felt to be an integral component of presenting the study, in order to provide assurance that the research findings are a true representation of the phenomena being studied. In order to avoid too much repetition of decisions and strategies that sit best in the context of the appropriate chapter, an overview of the quality of the study will be presented here. Much has been written to inform those seeking direction around this important part of presenting research. The work of the nurse researcher Janice Morse was particularly pertinent to the rest of this chapter.

4.12.1. A framework for quality.

There has been much debate around what constitutes a measure of quality when it comes to qualitative research (Bryman 2012). The chosen research method- that of phenomenology is considered particularly challenging when it comes to providing assurance around scientific rigour (Denscombe 2008) and it has been suggested that the criteria accepted for qualitative research per se do not translate to phenomenology (Norlyk and Harder 2010), with some challenging whether it is possible to use a generic set of criteria to assess phenomenological research due to its methodological inconsistencies and interpretative approach (De Witt and Ploeg 2005). The very fact that the researcher is called to bring components of themselves to the research process immediately leaves the phenomenological approach open to criticism around objectivity and bias (Koch 1996).

Since the 1980s the dominant yardstick for determining quality has centred on the extent to which a study can be deemed to be trustworthy (Morse 2016). At this time criteria were developed (Guba and Lincoln 1985, Lincoln and Guba 1989), that heralded a move away from the terminology used in quantitative research, towards the concepts of credibility; transferability; dependability (or reliability) and confirmability (or objectivity) that were seen to be essential to judge the trustworthiness of research. The wisdom of continuing to use this approach for over four decades without critical examination has been questioned (Morse 2015); despite the fact that it is the framework that is widely endorsed in qualitative research textbooks and for peer reviews. Morse (2015) made the case for returning to terminology of social sciences and using rigour as determined predominately by validity and reliability as the quality assessment framework of choice in qualitative research. The two concepts of validity and reliability are now briefly discussed and the ways in which this study aimed to achieve them, and therefore demonstrate rigour, are articulated.

4.12.2. Validity

Validity refers to the degree to which inferences made in a study are accurate and well founded (Polit and Beck 2012). In qualitative enquiry this is usually

operationalised by how well the research findings represent the phenomenon and how close the interpretation conforms to what the participants were trying to say (Conroy 2003). Validity is said to enable the theories generated from qualitative research to be generalisable and useful when recontextualised and applied to other settings. Key to validity is the engagement with the phenomenon being studied and the opportunity for the phenomenon to be seen. Morse (2015) considered factors such as sample size, sample selection and appropriateness of the selected participants to represent those experiencing the phenomenon to be important here and that the correct choice around these factors is necessary to reduce researcher bias. The methodology chapter describes how the sample was selected to achieve representativeness of the whole cohort of new HCAs and how optimal contact was achieved through the two sets of face to face in- depth interviews carried out within the time constraints of the study. The voices of the participants were encouraged to be heard by framing interview questions in a way that allowed individual experiences to be heard, the use of phrases taken from the transcripts to characterise the descriptive themes and presenting verbatim quotes in presenting the findings. Morse has written (Morse 1998), that validity is not something that can be awarded by committee but that it must be analytically earned. For this reason formal peer review was considered and then rejected when deciding on the research method. However supervisory sessions gave opportunity for oversight of the analysis stage of the study as several interviews were reviewed and discussed in detail,.

4.12.3. Reliability

Reliability is the dependability, consistency and /or repeatability of the study's data collection, interpretation and analysis and broadly speaking has been described as the ability to obtain the same results if the study were to be repeated (Morse 2015). In qualitative enquiry the major strategies for determining reliability occur during the analysis stage of the research- in particular the coding and interpretation of themes. The section on analysis in the method chapter aimed to give a clear account of how the process of

analysis was decided upon and how it was then executed including the move from descriptive to interpretative analysis. This has hopefully provided assurance that the study is dependable and that it has rigour. However, the concept of phenomenology acknowledges the uniqueness of a phenomenon to time, place, people and the interpretation of the researcher and so an aim of repeatability is unrealistic and redundant here. Member checking was considered and then rejected in accordance with the views of others (McConnell- Henry et al 2011 and Webb 2003) that it does not sit with the tenets of phenomenology.

4.13. Conclusion

This chapter has outlined how the underpinning principals of Hermeneutical Phenomenology were translated into the practical steps of a research method. There were choices to be made at various stages in developing the method and the final approach is designed to best answer the research question that aimed to explore the lived experiences of HCAs newly appointed to a role within acute hospital care, whilst being mindful of the practical constraints of the study. The method was informed by the work of van Manen whose interpretative approach to Hermeneutical Phenomenology had a resonance and practicality for the author. There has been a particular focus on describing the analysis of the study data as this was seen as being fundamental to the reliability of the research findings. The chapter has also illustrated the decisions that were made to ensure quality and to provide assurance that the study was conducted ethically. The next chapter presents the study findings.

5: Study Findings

5.1. Introduction.

This chapter firstly outlines the characteristics of the study participants and then presents an overview of the findings from the analysis of the two sets of interviews. The aim is for the relationship between the actual data, the description of the key themes and the subsequent interpretation to be transparent, with the conclusions rendered understandable and believable.

The findings are presented as two discrete entities from two moments in time for the participants. This sits within the framework of the Heideggerian philosophy underpinning this research that considers 'time to be the essence of being' (Faulconer and Williams 1985). The chapter shows how the descriptive analysis evolved into the identification of interpretative themes through carrying out the stages of analysis outlined in the previous chapter.

Four key interpretative themes were identified for each interview (3-4 weeks and six months) and these are presented separately, illustrated by direct quotes from the participants. This chapter explores the relationship between the two sets of interviews to give a sense of transition over time and Chapter 6, the discussion, presents the findings in relation to the literature that was reviewed after the analysis and considers the associated theoretical concepts.

5.2. The participants - the study sample

The final sample consisted of all twelve HCAs newly appointed to an acute hospital trust who met the selection criteria (new to acute hospital care) and expressed an interest in taking part by returning a reply slip. The demographic characteristics of the participants are outlined in Table 5.1. It can be seen that of the twelve, two were male and the average age was 35 years. Eight had previous experience employed in a caring role, but none had worked in a hospital setting before. The participants were working in a range of clinical areas across the trust and all were working full time (37.5 hrs) with off duty that covered 24 hours a day/ seven days a week involving long days/ night shifts of 12 ½ hours.

Table 5.1. Demographic details of the Participants. NB: None of the participants had worked in an Acute NHS Trust previously.

Participant number	Gender	Age	Previous caring role	Details if Yes	Previous job role if no	Post	6 month Interview
001	F	45	Yes	8 years Community Care Worker	N/A	Cardiac Theatres	Yes
002	F	40	Yes	12 years Residential Care	N/A	Acute Admissions	Yes
003	F	44	No	N/A	Cook in Residential home (Carer for sick husband)	Acute Admissions	Yes
004	M	26	No	N/A	Student	ED	Yes
005	F	31	Yes	2 years as carer in a Nursing Home	N/A	ED	No Left due to foot injury
006	F	26	Yes	7 years community learning disability care	NA	Acute Admissions	Yes
007	F	26	Yes	Community Carer for 3 years	NA	Acute Surgical ward	Yes
008	F	25	Yes	4 years Domiciliary carer	NA	Acute Medical Ward	Yes
009	F	40	Yes	10 years staff nurse in India 8 years UK residential care	NA	Acute Medical Ward	Yes
010	F	54	No	NA	(Carer for family members)	Acute Surgical ward	Yes
011	M	41	Yes	Residential Rehabilitation - 5 years Personal carer 2 years	NA	Clinical Decisions Unit	No Left to undertake Heavy Goods Vehicle training
012	F	21	No	NA	Shop Assistant	Children's ED	Yes

The demographic details in terms of age, gender and previous caring experience (Yes or No) of all 40 HCAs who joined the Trust at the start of the study, and from whom the study sample were taken, were obtained from the hospital Human Resources Department. This highlighted that the average age was 32 years. Five of the cohort was male and 36 had been employed in a role that involved caring (none in acute care). From this it can be seen that the sample selected for this study appeared to be similar to the full cohort of 40 HCAs in terms of age, sex and previous experience in caring.

5.3 Strategy for presenting the experiences of the participants.

The task when presenting the findings is said to be that of telling the complicated story of the data in a way that convinces the reader of the merit of the analysis (Braun and Clarke 2006, Miles and Hubberman 1995). The research findings in hermeneutic phenomenology have been described as an invitation to others to come and look rather than extracting generalisable statements that are true for everyone (Smythe et al 2007). The experience of others was sought through the academic literature and discussion at supervisory sessions.

5.3.1. Representing the themes

In presenting the findings the method of presenting the category or theme and illustrating this with quotes from the participants as outlined by (Cohen et al 2000) was used. In this method the overall themes are stated and then under each theme the sub themes describing them are named and presented. Although themes are largely abstract entities, explicit instances are used as evidence for their existence and unifying properties (DeSantis and Ugarriza 2000). Each theme is presented with an introductory paragraph outlining the theme and sub theme, followed by verbatim quote or quotes from the interviews that illustrate(s) the data used to derive each sub theme. The presentation of the findings is informed by guidelines that suggest that quotations from a range of different participants are used to add transparency and trustworthiness (Tong et al 2007) and that quotes are selected that clearly represent the point being made (Sandelowski and Barroso 2002).

5.4. The first interview.

5.4.1. Setting the scene

The first interviews were all conducted when the individual had been in post for 3-4 weeks. The participants had just completed their induction programme (see outline programme in Appendix 8), had had a period of two weeks as supernumerary HCAs in the clinical area and were now included in the off-duty as full members of the ward team. They now had a named 'Buddy' allocated to them for on-going support throughout a shift, although the opportunity for working on the same shift as their Buddy varied between participants.

For most of the participants, the interview started off with a conversation focusing on the practicalities of getting the role- the application and the interview and the first few days on the induction programme. The researcher felt that many of the participants were not used to talking about themselves with a relative stranger for any length of time, or responding to the open ended questioning approach that formed the basis of the interviews. At the start of the interviews the researcher had to give frequent prompts. However as each interview progressed the responses grew longer and participants moved towards expressing thoughts about themselves, relationships and feelings.

The interviews produced rich and multi-layered data as is usual for open ended semi structured interviews. The detailed analysis outlined in the previous chapter initially revealed 81 descriptive themes (QSR NVivo nodes) that were each identified in at least two of the participant's interviews (Appendix 13). These were subsequently grouped into twenty five broader analysis themes; nine interpretative themes and then four key interpretative themes. The descriptive analysis themes, the broader analysis themes and the interpretative themes that evolved from the first interviews are listed in Appendix 14 in order to give transparency to the development of themes. The title for these themes is taken from words or phrases used by the participants in order to reflect the lived experiences as they described them.

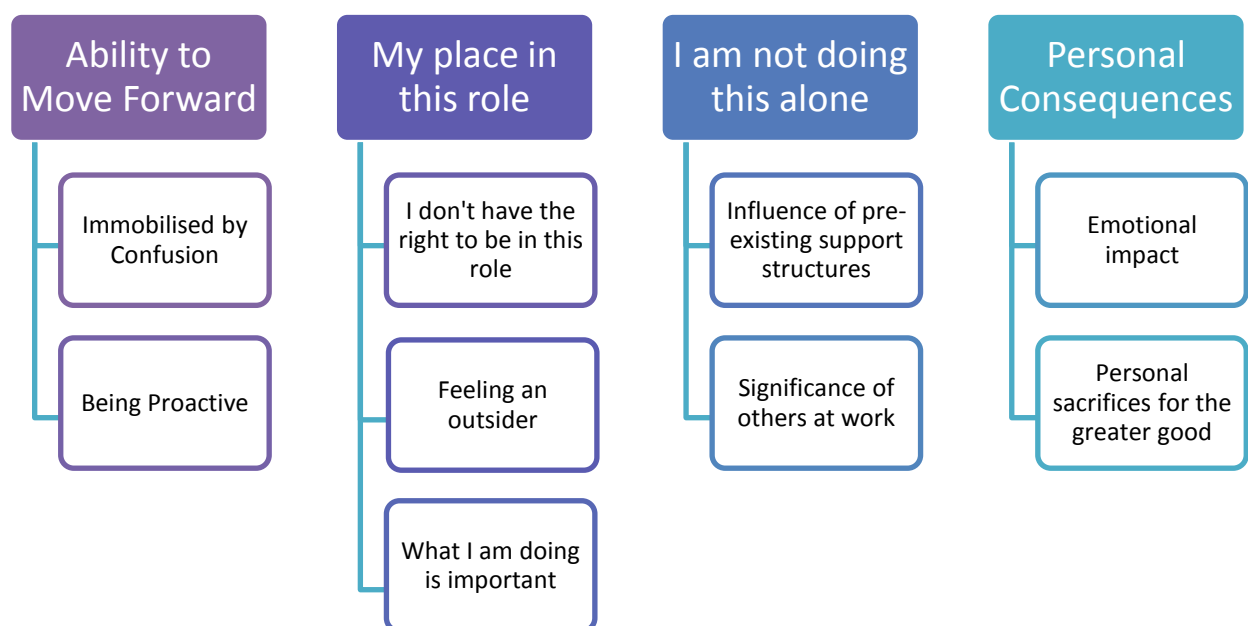
5.4.2. First Interview: - The Themes

There were four key interpretative themes from the interviews conducted at 3-4 weeks, these were:

1. **Ability to move forward**
2. **My place in this role**
3. **I am not doing this alone**
4. **Personal consequences**

These were informed by 9 interpretative sub themes as outlined in Fig 5.1. The four key themes are now presented, each introduced by the author and illustrated by selected verbatim quotes from the participants.

Figure 5.1 Themes from the first interview



5.4.2.1. Key theme 1: Ability to move forward

There was a strong sense that the participants felt they were at the start of a personal journey and wanted to move forward. Many had wanted the role for some time and saw it as the start of a new phase in their life journey. However, the early experiences in the role were not always as they had envisaged or at a speed they would have liked. The participants described a dichotomy between feeling powerless within the confusing reality of the role, set against a clear sense that this should be a moment to take control over the direction their lives were taking. They had come into the role with a clear sense of momentum and wanting to get on with things and were now facing the reality of feeling stalled by a sense of confusion and not feeling equipped to make things happen. The two sub themes **immobilised by confusion** and **being proactive** illustrate this.

5.4.2.1.1. Immobilised by confusion

A feeling of being lost, not in control and unsure came across powerfully. This started prior to actually starting in the role with the period from application to receiving confirmation of a start date being described as 'waiting in the dark' by several. The induction period and first few weeks felt disorganised and chaotic. They described feeling confused and overwhelmed. They were unsure how to find out what they didn't know. Rather than do the wrong thing they held back and did nothing.

One respondent likened their experience to being stationary in the midst of chaotic traffic.

007: It's like being in stuck in the middle of fast moving traffic in a foreign country. You know where you want to go but you can't get there. I tried to drive round the Arc de Triumph once and was too scared to move anywhere. My Husband had to takeover.

Several talked about not knowing what was supposed to happen between the job offer and starting in the job. They described feeling in limbo not knowing when their lives would move on and feeling powerless to question a process they were outside of and didn't understand. For example:

006: Well I had my interview six months ago- it was difficult waiting. HR wouldn't tell you anything- I was a bit stuck in limbo. I didn't know if that was normal or not. I didn't want to bother them too much.

003: Well I had my conditional offer on the 6th January- I filled in all the paper work for the DBS- got that back within the week and then I heard nothing... absolutely nothing until June 18th asking me to start two days later. So all that time I didn't know if I had a job or not.

Once in post the feeling of being surrounded by confusion seemed to intensify.

002: It just seemed I couldn't make any order out of it. You know watching people running around getting things done, always with something in their hand, or going to get something to put in their hands or to do something. I couldn't make head or tail of what was going on. I couldn't make any order out of it at all.

Within this confusion, there was a sense being fearful about doing something wrong and getting in the way. Individuals talked about being scared to do anything unless specifically told to do so. Several of the respondents talked about not wanting to touch things in case they damaged something. There was a sense of preferring to stand still and observe rather than do something that might turn out badly.

010: I was scared of doing anything, even though I was capable of doing things. I was anxious and when I did anything I had to ask- look this is what I have done- could you just come and check it because I'm not very sure. I am always double checking things.

001: You know, I can remember standing there thinking I aint going to move, I am just going to stand here and I am not going to breathe, I am not going to touch anything. I am just going to stand here. I wouldn't talk to anybody or anything.

004: I am sort of standing back from some of what I know I can do- because they've got pipes and tubes and catheters and drain bags. I'm sort of like 'no way am I touching that'. I am standing back because I am frightened in case I do something wrong- if I broke something that would be awful.

003: I was frightened of getting in the way, of someone tripping over me- so I just sort of stood back and tried to make myself disappear.

5.4.2.1.2. Being Proactive

For many of the participants there was an acknowledgement that they had actively positioned themselves at the start of a personal journey that could potentially lead to other things. There was a sense that their time had come and that it was now up to them to make the most of it. Several had chosen to become a HCA in order to expose themselves to the world of an acute hospital to see if they were ready to move on to other health care roles. In other words they were openly testing themselves. Several talked about having clear career aspirations to be a nurse. One was applying to medical school and wanted acute care experience prior to this.

005: I just think- that was my biggest regret not doing my nursing when I could have done it all them years ago- So I thought yep, I'm going to do that I 'm going to go and do it now- become an HCA to see if I still like it before I apply. I didn't want to apply for something if I wasn't sure that it was what I wanted to do.

006: Well I've wanted to get into the NHS for a while and then I had a baby so I had to put my life on hold. She's now a little bit older and it was the right time for me. I wanted to get my foot in the door within the NHS to become a health care worker and hopefully then on to become a nurse. So I just wanted to get all that experience first before hopefully going on to becoming a nurse.

008: Well I applied to be an HCA to see what it was like- to see if I had the skills to go into nursing. I just wanted to take a year out to test out my skills in the hospital setting. I wanted to try myself out in this setting.

As with two of the participants above, several felt that they had had career plans thwarted through circumstance. However several identified a clear external catalyst or life event that had precipitated the application for the current HCA role. Others had experienced hospital care as a relative or patient and having observed the role from a distance felt that it was something that they wanted to do. Others in this position wanted to give something back to the NHS. They felt that this was an important part of what they bought with them to the role and seemed to want to tell their story. There was a feeling that they had been given an opportunity and it was now down to them to make the most of it.

010: So when I was visiting I used to sit and watch the nurses work and I used to think 'I could do that' and 'I could do it even better'

004: In January 2013 I had an accident that resulted in being brought in to A and E and then I had a month long stay on ward 17. So I saw lots when I was there. Then I started volunteering in the oncology department as I was thinking of moving into health care after being a patient. I kind of decided I enjoyed it more than my day job so I decided to make the transition into a Health Care Assistant to see if it was something that I could do.

012: I think it's since having my baby. My daughter was in hospital- nothing too serious- just because she cut her head and I said to my sister- Oh I'd love to do something like that and she encouraged me to apply for it.

003: So that's what brought me here- we have definitely had our monies worth from the NHS and I wanted to give something back

There was a proactive attitude amongst the respondents who articulated that it was down to them to make the most of this opportunity. They were ambitious and were determined to progress. Whilst they realised that they had a lot to learn, they were prepared to work hard to achieve their goals. Mastering the skill of specific clinical tasks they hadn't performed before was a key focus in the first few weeks.

009: I want to work well here. I want to be a good part of the NHS. I want to learn more so that I can do something better. I have been given this chance

002: I'm thinking of progressing in some of my skills. I would really like to advance my skills- I want to do venepuncture, cannulation. I want to get on.

006: Well first of all I need to develop my clinical skills and then after the first six months I would really like to develop my training. I would really like to start on an NVQ or something. I don't want to wait for years to get on. I want to get stuck in now pretty much.

5.4.2.2. Key theme 2: My place in this role.

In the first few weeks as an HCA in acute care, participants were appraising the role they found themselves and were reflecting on their ability to perform successfully in it. After the induction programme and coming to the end of the two week supernumerary period, there was a strong sense that they were now facing the reality of a role that they hadn't properly thought through and that

they now didn't feel was legitimately theirs. The three sub themes that illustrate this role are: **I don't have the right to be in this role; feeling an outsider** and **what I'm doing is important**. These are highlighted below.

5.4.2.2.1. I don't have the right to be in this role

Initially respondents reported having feelings of self-doubt about their right to be in the role. Some reported feeling like an impostor looking in from the outside on those who were really meant to be there. They talked about going along with an illusion with a fear that they would be found out and exposed for being in a role that they were not entitled to. Some talked about themselves as if they were still in their previous role.

002: I was thinking- Oh I might not be able to make it. I might not be able to learn things here- I may not achieve- I may not be able to absorb things. I am not good enough for this role.

010: I thought- Oh my God – what am I going to do- I am going to fail the assessment. I won't get through it. I think I don't have the confidence in myself or the self-esteem. Perhaps I should not be here.

001: I had a bad day last week. I had done a few things that I should not have done- nothing serious. And I thought oh gosh I can't even do this – I can't even fetch a patient properly so how the hell am I going to be able to handle instruments and do obs.

008: I work as a carer in the community - We have to work on our own a lot and get things done. I am used to my role there. Here I am not so sure.

The HCA uniform was identified as significant for many as giving them legitimacy and kudos in the role. They felt it was seen by others as 'a marker for who I am and what I know' (002). The uniform also acted as a signal that they were now part of a different world. Others mentioned a false sense of security as whilst patients and the public saw the uniform as a guarantee of competence this was something that they (the HCA) did not feel.

010: Well actually the uniform made me feel like Super Woman. I found it so amazing how the power of this uniform – it's quite scary. It was scary because once you put this uniform on- people just assume that you are an

HCA, trained up, knows what she's doing... but I don't. But the power is amazing- it really is in a serious way.

006: I felt important..yeh I felt really important.. coz you are not just a carer like in my old job- in that job I didn't wear a uniform- and so people didn't recognise you as someone important. Whereas here I feel that they do see me as important- they have a lot of respect for you. They see you as a nurse- as an HCA. I felt really good.

003: I'm only a trainee, I've only been here a couple of weeks and I'm supernumerary. So I don't know what I am doing. But it looks like I do!. But that's because I'm wearing the correct clothing you know. The supernumerary badge doesn't make any difference. I've got all my pens in my pocket and my little watch on my lapel and to all intents and purposes I know what I am doing- but I don't.

5.4.2.2.2. Feeling an outsider

Participants talked about not knowing what was expected of them or how to behave. They spoke about joining the NHS where they presumed that there were systems and processes in place but they did not know what they were. They did not know the rules and worried about unwittingly breaking them or crossing lines that were not explained or clear. There was a language they didn't understand. Some talked about watching things from a distance or from the outside and several literally found it difficult to get into places.

010: And it was all really daunting because you had to remember lots of things- like all those door codes- there was this code and that code and I felt that I would never remember them-that I would never get in anywhere!.

008: And then it's the names of things that are bothering me. Like it's the names of all the instruments you know. They don't just call a knife a knife it's called something far more complicated than that (laughs). I don't know why they don't just call it a knife.

5.4.2.2.3. What I'm doing is important

Whilst most of the participants had had some previous experience of a caring role, several admitted to not really knowing what HCAs in hospital did and they were now beginning to appreciate the significance of what they were doing on a day to day basis. They were realising that the role they were now doing was different from what they had done before and often from what they had

envisaged when they applied for the role. For some, the image of working in acute hospital had evolved through watching television dramas which they now realised bore little resemblance to the realities of what they were doing in their current role.

004: When I found out that I would be working in the emergency department I watched an inordinate number of episodes of '24 hours in A and E' – although err it's not quite the same as that (laughs). It's not always such a happy ending and the patients are far more complicated sometimes.

011: Well watched Holby and all that sort of nonsense because I knew that working in the NHS would be different, and I thought that I quite liked the look of it- it's the adrenalin .But the reality is not quite like that. It's sort of deeper somehow.

However, more individuals admitted that they started in the role not really knowing what to expect. Several did not know which area they would be working in right up until the first day. They were not sure what the work would involve or what kinds of patients they would be working with.

002: If I am perfectly honest, I came into it not really knowing what an HCAs role was. I thought it would just be general stuff, stocking up and that sort of thing- I didn't realise how involved it would be.

006: I came into it a bit blind really. That sounds a bit bad- but really I had no idea.

For some this was a conscious decision.

001: I just thought- no I want to go in completely fresh not having any idea of what I'm letting myself in for- I don't want to know anything – I just want to get in there and grab it by the balls so to speak.

After three to four weeks on the ward many were comparing the role to what they had done previously. For those for whom the role was the first time in a formal caring role, the significance of working with acutely unwell people was highlighted as important.

010: This is not just any job, The people here are not like you would work with in other jobs. They are not like garments, they are people. Frail, sick vulnerable people. And you really need to know what you are doing.

004: Well I have been a life guard before – so I've done quite a bit of first aide and things like that- but not as a job, this is so different. The people here can be really sick. What you do here really matters

Those with residential care home experience were becoming aware of the difference in the case load of patients on the acute wards and the different demands this would put on them in their role. Those who considered themselves experienced carers were being exposed to new things and some described working outside their comfort zone. Patients were referred to as being more complicated with 'lots going on' and there was a perception that they had a more challenging set of needs than patients they had previously cared for. Participants who had worked as care workers visiting patients in their homes for set time periods for the purpose of undertaking prescribed care activities talked about now being with patients for longer periods of time. There was a feeling that they were now being exposed to things that their previous roles would not have allowed them to see.

005: Well in a nursing home I just did nights and so the patients would be mostly asleep. I didn't really see a lot of them. I didn't really know very much about them. I didn't really have to do too much for them.

007: Well I didn't think that it would be quite like this. I knew that I was going to be working on a diabetic ward but I didn't really know what that would mean. You need to know all about the medical side of things here too.

An anxiety about being involved in the care of patients who were medically unstable and needed someone to care for them who knew what they were doing was identified.

001: The first patient I introduced myself too was wearing an oxygen mask and he was quite poorly. And I was excited but really scared as well because it was real. I was actually dealing with real sick patients.

Working with patients who might die was mentioned by over two thirds of the participants. There was a fear of not noticing that a patient was deteriorating and then concern as to how they would cope with the actual death of a patient. Respondents often recounted stories about their own personal experiences with death.

006: I worry about someone having a cardiac arrest and dying. There was an arrest on the ward the other day and it really shook me up. It was nothing like you see on the telly or when you practice on the dummies . I worry that I would miss it happening and I wouldn't pull the emergency button. I didn't think I'd feel like this. It kind of scares me. Seeing things in real life.

001: Well my Mum passed away in hospital and when we did the training on bereavement it really got to me because the thought of her being wrapped in a sheet like that. Because obviously I have never worked in a hospital environment. I don't know how I would cope.

Whilst there was a realisation that the HCA role in an acute hospital trust setting was different to community or residential care. The significance of caring as being common to all these roles came through in the interviews. Many of the respondents identified themselves as being good carers from previous experiences. It was this feeling that they were able to give good care even in the confusing environment they found themselves in that was helping to keep them positive during the initial weeks.

002: In the background I had the knowledge that I had as a carer and I think that I have equipped myself with all the values and somehow these are not much different in a different setting like this.

010: Its not so much about the work itself- but its about how I've made a difference to a patient- how I have cared for them. That stands out to me on a daily basis- whether I have made a difference by caring.

5.4.2.3. Key theme 3: I am not doing this alone

Whilst the interview was framed around exploring experiences from an individual perspective it was clear that other people significantly influenced how this experience unfolded. All of the respondents talked about the influence that other people had on their experiences in the first three to four weeks in post. Established support structures were valued but there was a growing awareness that individuals in the work place had an important part to play. The two sub themes that informed this key theme are: **Influence of pre-existing support structures** and **significance of others at work**.

5.4.2.3.1. Influence of pre-existing support structures

Friends and family were often identified as being significant in encouraging the individual to apply for the HCA role and were continuing to offer emotional and practical support over the first month. Many identified young children as giving them a reason to take on the role and a partner as keeping them going if they had had a difficult shift.

003: My family were willing me to get through it and were very supportive, My daughter was really encouraging me- 'Mum you could be so good'. She's pushed me I suppose and said 'Go for it'. That's what I needed to get me to do it.

001: I talk about it all to my daughter- she is only ten but she likes to know everything. Well obviously I can't tell her everything- but we do sort of talk on our little shunts in the car and she will say when I walk through the door- is everything OK? Is everything OK today? In a sort of old fashioned sort of a way. So I suppose I do talk to her a lot about it really. It makes me feel better.

002: Well my husband is there- he's always there and he's asking me 'are you enjoying it. Do you like this job? How do you like it? And he is always asking- 'How was your day- So he always asks me how things are. We talk about my day – we share things about it. If its been busy I talk to him about it. It's been good to talk through things- he usually asks how I am before I say anything.

010 My husband- sometimes I go home and let it all out. I need to do that. I need to let it out and then realise that its OK that I have made a difference to a patient- he helps me to do that.

There was an acknowledgement that significant others- in particular family members and children had had to make sacrifices and compromises in order to support the respondent in the role. This was particularly related to support with child care.

004: I am a single Mum and my Mum was a bit worried about the effect the long shifts would have on my daughter – she is still quite little. I don't get to put her to bed every night now and that has been difficult for us as a family. I think my Mum might be finding it hard.

5.4.2.3.2. Significance of others at work

At the time of the first interview participants had just finished their induction programme. Several participants talked about making friends on this programme and how this had helped them. They sometimes used the term 'we' when talking about the early days in their role as if this was a joint experience.

002: It was quite daunting how many people were there. But I sought of made a little friend straight away, clicked with someone straight away. Loads younger than me, a bit weird really but we had so much in common and we became friends really quickly and sort of stuck together through all the training.

The ward team were seen as a positive influence on the experience for the participants over the first few weeks. They were perceived as being friendly and welcoming with individuals (often the Buddy and ward sister) being mentioned by name as being particularly helpful. Participants acknowledged that they had more people around them as a team in this role than in previous caring roles in the community or in residential care and this was seen as a positive thing- they did not feel so isolated.

005: Everyone made me feel very welcome. They are all quite helpful and they are always willing to show you things because obviously we have not seen everything yet; we still have a lot to learn.

006: Well the first day or so was quite a challenge- but everyone was really nice and supportive and showing me things and watching me do things just to make sure I was doing alright- but it was very scary.

With the Buddy- it was not so much that they were there to work with regularly but the attitudes they displayed toward the respondent that were perceived as significant.

002: Sharing things with my Buddy has helped my confidence. He now tries to leave me on my own sometimes. He says that he believes in me and has confidence in me and I thanked him because I know that he is trying to make me more confident by the way he is with me.

001: And then there's my mentor, my Buddy- I can talk to her quite openly because we seem to be on the same wavelength. We like things the same way-i.e. organised (laughs). She lets me be me and supports me like that.

Several participants equated support with a sense of belonging. They anticipated that they would develop more of a sense of belonging as the weeks progressed. They wanted to be accepted and fit in.

003: Also – I'd like to think I would integrate slightly more with the team in a few more weeks and then I might feel more supported. I do sort of feel part of the team but at the moment I don't really know them. I'd like to feel more like I belong here, yes that I really belong.

5.4.2.4. Key theme 4: Personal Consequences.

From the vantage point of three- to four weeks, participants looked back and spoke freely about their responses to the first few days in post which had been quite emotional for many. A month into the role there was a growing realisation of the personal commitment that the role would entail. The sub themes that illustrate this final key theme are: **emotional impact** and **personal sacrifices for the greater good**.

5.4.2.4.1. Emotional Impact

The start of their role as an HCA was described in vivid emotional language by many of the respondents. Many used the word 'excited' to describe the feeling on being told that they had been successful at interview and to describe how they felt before the first day.

008: Ah it was fantastic. I even cried for joy. I thought hooray!!

009: I was so excited when I knew that I was going to be an HCA

004: I really really was excited- I was really itching to get started.

The first day on the ward was particularly emotional for many and most of the participants chose to talk about it. Several described this first day as scary and frightening. Some said that they were sick with nerves.

002: The first day was horrific for me. Emotionally It was just overwhelming

007: My first day on the ward I was really shaking. I was shaking so violently that I was nearly sick. I was palpating, I felt dizzy and hot. I just felt awful. I was so so frightened, So very aware of how inexperienced I was.

006: I was very nervous. I would say like literally having some sort of mini panic attack because it's just so different to what I was doing before. I was like Oh my God how am I going to be able to do this. It was all quite a challenge to get through.

5.4.2.4.2. Personal Sacrifices for the greater good.

Participants talked about things in their lives that had changed in order to accommodate the practicalities of their current role. They were noticing that they had less time for themselves and that they often felt tired and exhausted. The 12 hour shifts were mentioned often- several admitted that they had not thought through how these shifts would impact on their day to day lives

006: The 12 hour shifts are hard. I've had to ask a few people that I know how they get through them. It makes you feel tired- I guess I'm not used to them .I've got to learn to pace myself. It will all be worth it in the end (laughs)

Several spoke about having less time to spend with their family- particularly with young children

001: The biggest thing if I'm honest has been the upset in routine for me with my daughter. I was always there to take her to school and to pick her up- so this has been like a massive change. I have to drive all the way to my Mums to drop her off which makes the time that I am not with her even longer now.

5.4.3. Overview of the first interview.

The findings from the first interview illustrate the lived experience of the participating HCAs 3-4 weeks into their new role as an HCA in acute care within a hospital environment. Analysis of the interviews revealed nine initial (sub) interpretative themes, which subsequently formed four key Interpretative themes that get to the core of the experience for the participating individuals at this moment in time. These key themes were: **ability to move forward; my place in this role; not doing this alone**, and **personal consequences**.

5.5. The second interview

5.5.1. Setting the scene:

The second interview took place when the participants had been in working in the Acute Trust as an HCA for 6 months. Of the twelve HCAs originally recruited to the study, ten were in post at this time and took part in this part of the study. Two of the original sample had left the Trust. They were both happy to give the reason behind their decision to leave - one had returned to previous employment as a Heavy Goods Vehicle (HGV) driver for financial reasons and the other had been forced to leave on health grounds and was back working in retail. Of the remaining ten participants, two had moved wards in order to be able to work more acceptable (shorter) shift patterns and one had reduced her hours but had remained on the same ward. These details are summarised in Table 5.1.

The practical arrangements for the second interviews mirrored those for the first. However, for the second interview, the date and time were often arranged by the participant themselves, rather than through the nurse in charge. The participants seemed genuinely pleased to see the researcher again after the six month time gap and, more often than not, welcomed them onto the ward area with the offer of a hot drink to have during the interview. The impression was that participants were welcoming the researcher into an environment where they now felt at home.

The second interviews differed from the first in that they lasted longer (an average of seventy five minutes as opposed to sixty five for the first). There was less time spent on the practicalities of the interview (the tape recorder, written consent etc.) with participants seeming more inclined to talk unprompted with the transcripts indicating longer periods of uninterrupted speech.

The second interviews were analysed in the same way as the first interviews as described in the analysis chapter. The detailed analysis initially revealed 114 themes (QSR NVivo nodes- Appendix 17). These were subsequently grouped into twenty nine broader analysis themes; ten interpretative sub themes and

four key interpretative themes. The link between the descriptive analysis themes, the broader analysis themes and the interpretative themes that evolved from these are illustrated in Appendix 18.

Whilst the second interview took place at one moment in time and was analysed as a discrete entity, participants inevitably looked back to the first interview and reviewed their experiences from this time. This, together with an interpretive overview of the first and second interviews presented in the next chapter, helped to inform the researchers growing sense of the experiences of the participants over the 6 month timeframe of the study.

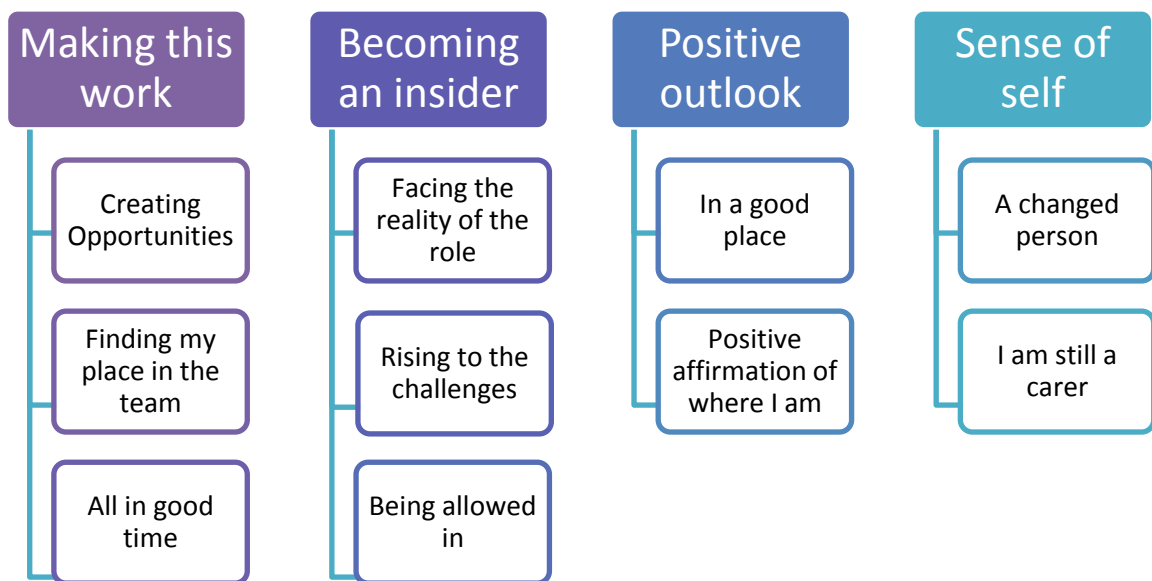
5.5.2. Second Interview: The Themes

There were four key interpretive themes from the interviews conducted at 6 months. These were:

- **Making this work**
- **Becoming an insider**
- **Positive outlook**
- **Sense of Self**

These were informed by ten interpretative sub themes as outlined in Figure. 5.2. These four key themes will now be presented, each introduced by the author and illustrated by selected quotes from the participants.

Figure 5.2 Themes from the second interview



5.5.2.1. Key theme 1: Making this work

It seemed that participants had spent time observing the workings of their wards and the ward teams and working out where they sat within the ward team. They were now starting to use this knowledge to their advantage in order to take some control over their day to day working lives and the momentum and direction of travel in their development as HCAs in an acute care ward environment. In the main they were focusing on making the current experience a good one for themselves rather than considering moving on to new things. This key theme is illustrated through the three sub themes **creating opportunities**, **finding my place in the team** and **all in good time**.

5.5.2.1.1 Creating opportunities

Participants talked about actively creating situations in the work environment that maximised their opportunities for seeing how things were done. They felt they learnt the most through doing, through the day to day exposure that working on the ward gave them. The induction programme and Care Certificate

rarely got a mention at this stage. Many participants had developed strategies for getting through the working day in a way that made it feel more organised and manageable. Participants were using their initiative and pushing themselves forward through looking for opportunities to attend study days and to become competent in procedural clinical skills. There was a realisation that there was still a lot to learn and that it was down to them to make the most of the opportunities that they had been given.

003: The advice is to keep going because eventually the fear is replaced with confidence. The more you do it the better you get. Don't be afraid to ask and if at first you don't get all the information that you need then ask again and keep asking until you have got what you need in your brain and its fixed there.

008: You have to watch what others do and then try it out for yourself- you say something that you've maybe heard a couple of times and see what reaction it gets and then modify it or simplify it a bit. Learn as you go.

5.5.2.1.2. Finding my place in the team

Participants had spent time observing the characters in the teams that they were working in and working out the team dynamics and ward politics. They had realised that team members responded to them in different ways and expected different things of them. They were responding to this by actively seeking out certain individuals to observe and learn from and had learnt to behave differently depending who they were working with. Participants were aware that the team were also working them out as individuals during these early months. Whilst the buddy or mentor was often identified as an important member of the team for participants, for many the Ward Sister was seen as a key figure in influencing how the first six months had gone.

004: There has been the odd one or two.. Well let's say I have less than a positive opinion of some of them. You try not to engage in the departmental bitch as it were. One day one of the band 7s pulls you up for something and then the next day another one will tell you to do something that you got pulled up for the day before. I found that really difficult to be honest, the inconsistency.

007: I find that I'm behaving differently depending on who is in charge off the shift, You kind of need to know what to do for an easy life and also you need to know when you can break ranks and stick your neck out.

002. Well the staff are a mixed bag- some I know well now and others not so well. It's a bit clearer to me now each member of staff works- each of them have their own way of doing things and their own approach to care. I have my own ways too I suppose and if it's not the same as the person I am working with that can be difficult sometimes

5.5.2.1.3. All in good time

Whilst initially wanting to move forward with an agenda and a time scale for their anticipated progression in their roles, many of the participants now expressed a sense of having reached a plateau phase. It was as if they were actively taking stock before deciding how and when to move forward again.

005: It's a bit like skiing- (not that I've ever been skiing!) sometimes you have to use the poles and other times you free fall and trust it will be alright for a while.

012: I can't decide if I want to be a nurse anymore- I realise now that it would be a big step and to be honest I feel happy with what I have at the moment.

There was an acknowledgement that whilst they had ideas and plans and could see things that they felt needed changing, now was not the right time to attempt to do so.

002: At the moment it's not the right time for me to try and change things. I can't say 'no don't do that'- like with the moving and handling- its difficult to feedback I think- maybe I will get better at it but I can't do it at the moment.

5.5.2.2. Key theme 2: Becoming an insider

Through facing the realities of the role, and rising to the challenges of the role there was a sense that participants felt they were becoming bona fide HCAs within their ward areas. There was a focus on becoming part of their ward rather than 'working for the NHS', which was a phrase often used at the first interview. Many described successfully rising to challenges of caring for particular patients and through this seeing that they were now actively in the role. This was helped by a sense that they were being allowed into a team and now had an

appreciation of how this team worked. They described feelings of being valued and a sense of belonging. The three sub themes for this key theme are **facing the reality of the role; rising to the challenges**, and **being allowed in**.

5.5.2.2.1. Facing the reality of the role

Participants were now appreciating the uniqueness of their HCA role and how it differed from both what they had anticipated and what they had done in previous caring roles. They were also observing registered nurse colleagues and some were struggling to appreciate the boundaries between their role and that of the registered nurse.

004: It does seem a bit confusing this role at times- what is the remit of the qualified nurse and what is my remit. It takes a bit of getting used to.

006: The biggest thing is the divide between the qualified nurse and the HCA- because sometimes you get told something is the qualified nurses role and then the next day you get asked to do it.

The need to understand the medical condition of the patient and appreciating how this impacts in their role as an HCA in an acute hospital setting was significant. Several highlighted the unexpected impact of the patient's mental health. Others admitted that the role was more emotionally draining than they had anticipated.

002: So now I know more about how to talk to them about their medical conditions and know what things they will need because of what is medically wrong with them. I did not really need to know this before.

007: Well you can't tell what's on their minds and I do sometimes say to myself that I'm not going to be able to cope with the mental bit of this role. I have got used to the dementia patients more now- as long as they're not aggressive- I struggle with trying to look after the ones that are aggressive because you don't really know what they will do next. But I think I'm getting better.

005: It's the emotion that's come with the role that's been a bit of a surprise. It's everything physically that I thought it would be-but I really wasn't prepared for all that emotion- getting close to people.. it can be very emotional.

Several talked about the potential consequences of them failing to recognise when a patient was becoming unwell. This was a key difference identified from the type of caring role they had done previously.

012: Sometimes I do worry that I have not done something or missed something and I don't like lying there at night wondering if there is anything I should have done.

006: I worry that I will miss something and that one day a patient will be found dead and it will be because I have missed something.

Some participants talked about faults they had observed in the system and were questioning the way in which things were done – particularly if things on the ward were not done in the way that they had been taught in practice. The reality of the work involved in the role was hard for several participants- in particular the long 12 hour shifts and the shift patterns.

002: Sometimes I get put to work somewhere at the start of a shift where I am not really needed and other people are crying out for help and are really busy, but who am I to say. I think the staffing could be a bit more organised.

003: Well it can be exhausting. You are your feet a whole lot more than I was in the community. It can be so so tiring. It gets very stressful like when there's everyone in the bay needing the loo at the same time.

007: The long shifts are hard, really hard if it's busy- particularly the night shifts- I am still not used to them. I find it really hard to sleep in the day time and I have to keep myself going with energy drinks

5.5.2.2.3. Rising to the Challenges

There was a sense that participants felt they were starting to see order through the chaos. They were beginning to appreciate, and indeed quite like the fact, that no two days were the same and were enjoying a sense of achievement that came from feeling that they were coping well with this.

Participants felt they now knew what they were doing on a day to day basis and were able to get on with things without having to ask too many questions. They sometimes felt that they were being tested and gave examples where they felt that they had risen to a particular challenge.

004: *In the beginning I used to just hang around a bit waiting for direction, I didn't know what needed to be done or where things are kept- I do now and I can get on with things.*

006: *well- take today for example- I have been with a really poorly lady all day- I found her poorly at ten o' clock and she should really have gone to ITU there and then – and I have been with her every minute until she finally got moved. My Ward Sister thanked me for what I'd done – so that made me feel really pleased with myself.*

5.5.2.2.4. Being allowed in

The interviews contained a lot of dialogue around this theme. Participants felt that they were now trusted and valued by the team and felt that they now belonged in the team and in their role. Support from the team and friendships within the team were important. It seemed that the links made on the induction programme in the early weeks of employment were no longer significant. Participants talked about no longer waiting in the wings or on the side lines. Several talked about now feeling able to touch things rather than standing back. It was as if they now felt ready to impact on their immediate surroundings rather than being a bystander. Feeling able to touch patients was a significant factor for a few- particularly those working in more high dependency areas.

001: *The registered nurses are quite happy to leave me on my own now. In the beginning you'd always have someone with you, they would make sure that happened even when they went for their lunch breaks but now they let me be on my own. I think they trust me now. I know what's what now.*

007: *And the good bit is- I've met a lot of new friends here- it's been a lot of fun. I can connect with them and you get to talk about things inside and outside of work. I feel I've sort of clicked with them. They invite me to their dos and things which is great.*

010: *I think the team have got the measure of me now. In the beginning I was sort of on the edge of things- but they know me better now and they've let me get on with things at my own pace.*

Being in a position where they were exposed to things they would not have been involved with before having their current HCA role was a key theme for many. Caring for the acutely unwell patient was significant for them. Several talked about a time they had spent involved in the care of dying patients,

particularly those who had suffered a cardiac arrest. These were new experiences for them.

012: I would like to get more confident about when patients are going off-being there scares me a bit because I've never really been around dying patients before- I don't really know what to do. I just feel a bit lost. It's really important to get things right ... it's a really important thing to be doing.

006: I remember my first cardiac arrest- I was in tears for the first time here. It was the shock of the enormity of it all. You don't expect it. It was just coming face to face with the reality of the job I think.

5.5.2.3. Key theme 3: Positive Outlook

Participants conveyed a strong sense of positivity and optimism throughout the interviews despite an honest realism. They seemed now to be in a good place in terms of where they were in their role and their sense of achievement at getting to this point. Despite clear time framed milestones for moving on and progressing voiced in the first interviews, participants were now settled where they were and were not looking to move on. Many chose the interview to affirm that their decision to become an HCA had been the right one for them and several said that they wished that they had done this earlier. Positive feedback from work colleagues and family supported the sense of positivism that came through at this interview. The two sub themes for this key theme are: **in a good place**, and **positive affirmation of where I am**.

5.5.2.3.1. In a good place

Many participants said that they were happy with where they were in their role and in fact were not so sure now that they wanted to move on to other roles just yet. Many voiced that they had no regrets and in fact said that they wished that they had done this sooner. Key to the perceived success in the role for many was the continued day to day practical support from family members.

001: I know I said that I was keen to do my nursing, but I'm happy where I am for now – I've progressed so much in this role- I might push for my nursing in a couple of years or so. But not at the moment.

007: Well I'd do it all again (laughs). In a way I wish I'd done it sooner. I have no regrets what so ever. There is a still loads to learn and I'm really looking forward to it.

5.5.2.3.2. Positive affirmation of where I am

Positive feedback from key individuals whom they respected was important for many. It was important that family members had expressed pride in them. In the work environment, examples of how ward sisters had been involved in support and feedback, were mentioned by several.

Participants looked back over the last six months and shared their sense of achievement during the interview. They admitted their naivety at the beginning and a sense of pride at where they were now.

009: Its the support from the team that has got me through. They have always been honest and helpful telling me how I'm doing- particularly the ward sister who I know is really busy- but if I was struggling and needed help with anything I would just go to the ward sister and ask. She's been really good

012: Well they are all really pleased that I've stuck to it - they are really proud- especially my Mum – and that makes me feel good. I'm quite proud of myself to be honest- I was a bit like a rabbit in the headlights at the beginning – but I've come through that now- thanks to all the support I've had really.

5.5.2.4. Key theme 4: Sense of Self

Within all the dialogue about how they were working in relation to others, participants made space to talk about themselves as individuals- what they perceived as changing and what they felt had remained a constant. The sub key themes that illustrate this are: **a changed person** and **I am still a carer**.

5.5.2.4.1. A changed person

Participants were reflective about how they felt they had changed as individuals throughout the six month period. Key to this was a perceived increase in confidence- in particular around how they approached people and their ability to initiate conversations. Participants gave rich accounts of occasions where they had behaved in a way at work they would not have done six months ago. They

chose examples of when this had made a positive impact on patient's experiences. Several talked about feeling more settled than they had done before. For several the change in themselves had been noticed and remarked upon by family members. More than one participant talked about finding themselves "as a person" as a result of their experiences as an HCA.

009: I feel like I've found myself really. I really do. People who know me have said that I seem a lot more confident in myself – so I suppose I must be (Laughs). I certainly feel I am in the right place for me now.

012: I am not the shy wallflower at the back any more. Also, I think I'm so much happier than I have ever been before because I love my job. It's made me believe in myself. That has surprised me a bit and other people have noticed it about me too- how I've changed. Apparently I'm glowing!

006: I think I've become me through doing this job, I really do.

5.5.2.4.2. I am still a carer

Throughout the interviews participants chose to tell stories of situations where they felt they had made a difference to patients through caring. Amidst the acute care environment with its unknowns and unpredictability, there was a sense that their self- identified pre-existing core values around caring, and in particular the emotional involvement with patients, remained important. There was a sense that this was at the heart of what they saw as their role and it was something they could relate to and felt confident to talk about. This focus on caring remained a key constant whilst other things were evolving around them. One described it as having been an anchor.

003: It's what I like about the job; It's the personal care- the being with the patients and listening to them when they need somebody to talk to. ~It's the main thing. It's been like having an anchor when all around is like a choppy sea.

007: I am first and foremost a carer I am. Although the role says Health Care Assistant- that covers loads of different things – but I am a carer- I look after a person- their well being – that's who I am.

5.5.2.4. Summary of the second Interviews

The findings from the second interview illustrate the lived experience of the participating HCAs six months into their new role as an HCA in an acute care hospital environment. Analysis of the interviews revealed ten initial (sub) interpretative themes, which subsequently formed four key Interpretative themes that get to the core of the experience for the participating individuals at this moment in time. These key themes are: **making this work; becoming an insider; positive outlook and sense of self.**

5.6. Conclusion

This chapter has presented the findings of the independent analysis of the transcripts from the interviews at 3-4 weeks and 6 months using the approach outlined in chapter 4. It has highlighted a rich insight into the participant's experiences at two moments in time. This is captured through four key interpretative themes for each interview set. There was a growing awareness, whilst analysing the interview transcripts and writing up the findings, that there were constant, emerging and diminishing themes across the two interviews which had the potential to provide further insight into the experiences of the participants experience over the study time frame. This prompted further exploration of the themes from the two interviews. This is outlined in the next chapter.

6: The lived experience over time

6.1. Introduction

This chapter provides a fuller understanding of the lived experience of the participating HCAs over their first six months in a post in an acute care hospital environment. The findings from the previous chapter are developed through an exploration of consistent, emerging and diminishing themes across the two sets of interviews in order to give a deeper insight into the experience for the participants. Four key themes emerge around **becoming an insider, belonging, positively becoming** and **a sense of self**.

The second section of this chapter goes back to the literature identified in the initial literature search in Chapter 2. It looks at it again in more depth with a focus on the findings of the study. This is in order to give the researcher (and the reader) an appreciation of what is already known in order that this can inform a deeper understanding of the experiences of the participants.

Figure 6.1 gives a visual representation of the experiences of the study HCAs interpreted through the further exploration of the interview themes as described in this chapter.

6.2. Rationale for further analysis

To this point, the findings from the analysis of the transcribed interviews from two separate stages during the study have been presented separately. This gives an idea of what it was like for the participants at two moments in time, which was the intention, and sits with the underpinning Heideggerian philosophy and research method. However, during the analysis stage, it became apparent that the participants were not just focusing on the moment of the interview, but were looking forward at the first interview and backwards at the second. This meant there was potential for the interviews to illuminate the experiences over the time frame of the study. In order to attempt to capture this, the over-arching themes which gave meaning to the experience of the HCAs over the six month period of the study were explored. This approach has been taken by other

researchers conducting studies with the same participants over time (Snelgrove 2014) and fits with the concept of the Hermeneutic cycle (Gadamer 1989) with the moving between the whole and the parts which is a fundamental concept in the underlying philosophical framework of this study. The aim was to ensure that the study remained focused on its original main aim which was:

What is the lived experience of newly appointed Health Care Assistants (HCAs) during their first six months in a role within an Acute Hospital setting.

It was intended to go back to the original descriptive themes, to the heard voices of the participants, in order to see if looking at the interviews as a whole endorsed the original analysis of the two interviews separately and whether any further interpretative themes emerged that shed light onto the experience over the six month time frame. This was a way of immersing in the data in a different way and so providing a degree of assurance that the interpretative analysis was getting at the true meaning of the participants experience Snelgrove (2014) referred to this as maintaining a bottom up approach without imposing a priori theory on to the data. Although it needs to be acknowledged that the researcher had a different understanding of the experiences of the participants at this point than at the beginning of the analysis stage of the study.

6.3 Looking again at the themes

The descriptive themes from the two sets of interviews were looked at again to identify:

- Themes that were consistent across the two interviews i.e. the two sets of interviews both addressed the theme and demonstrated affirmation of the themes across the six month time span and / or experiences in the first interview were endorsed by the second interview (Appendix 19).
- Themes that developed or diminished (evolved) across the six month time span (see Appendix 21).
- Themes that appeared to be unique to the specific time of the interview (see Appendix 22).

It is likely that this interpretation taken from the findings of both sets of interviews was informed by the act of interpreting the two sets of interviews separately, and this needs to be acknowledged. This process helped to identify the interpretative themes thought to best represent the lived experiences of the HCAs. The key Interpretative themes from a review of overarching and evolving themes are presented in Table 6.1.

Table 6.1. Key Interpretative themes from a review of overarching and evolving themes from the two sets of interviews.

Interpretative theme for the lived experience (Taken from Table in Appendix 20)	Key interpretative theme
Finding their way in	Becoming an Insider
Now Feel able to impact on the situation they are in- they are in the picture	
Now have the knowledge of the workplace	
Equipped to deal with what the job brings	
Increased sense of legitimacy/ belonging	Belonging
Sense of independence / can be relied on by others	
Being Accepted and Supported by the team	
No longer relying on external badge of honour to make them feel important- its what they DO that is important	Being in the role
Appreciating the unique importance / significance of the role	
Realisation of core values of caring and the significance of this to them	Staying true to themselves / finding themselves
Finding themselves	
Where I am now is actually OK	
Change in priorities over the 6 months	Adjusting to the role
Seeing that they can cope with the unpredictability	
Adapting to the demands of the role	
Comparing and contrasting to previous roles	
Gradually taking stock- slowing down the pace (expectations of moving on)	Proactive – Having some control over their experience
You have to make the most of things	
Being Accepted by the team	Not doing this alone
Importance of developing relationships	
It feels like there is always someone to turn to.	
Attitude of the Buddy is important	
Positive significance of the ward team	
Families support has been significant	

Table 6.2. Bringing the themes from the independent analyses and the overarching analysis together.

<u>3-4 Weeks analysis</u>	<u>6-7 months analysis</u>	<u>Overarching</u>
	Becoming an insider	Becoming an Insider
The role what it is and my place in it		Belonging Being in the Role Appreciation of the Significance of the role
Not doing this alone		Not doing this alone
Personal consequences	Sense of Self	Staying true to themselves. Finding themselves
Ability to move forward	Making this work	Proactive
	Positive outlook	Adjusting to the role

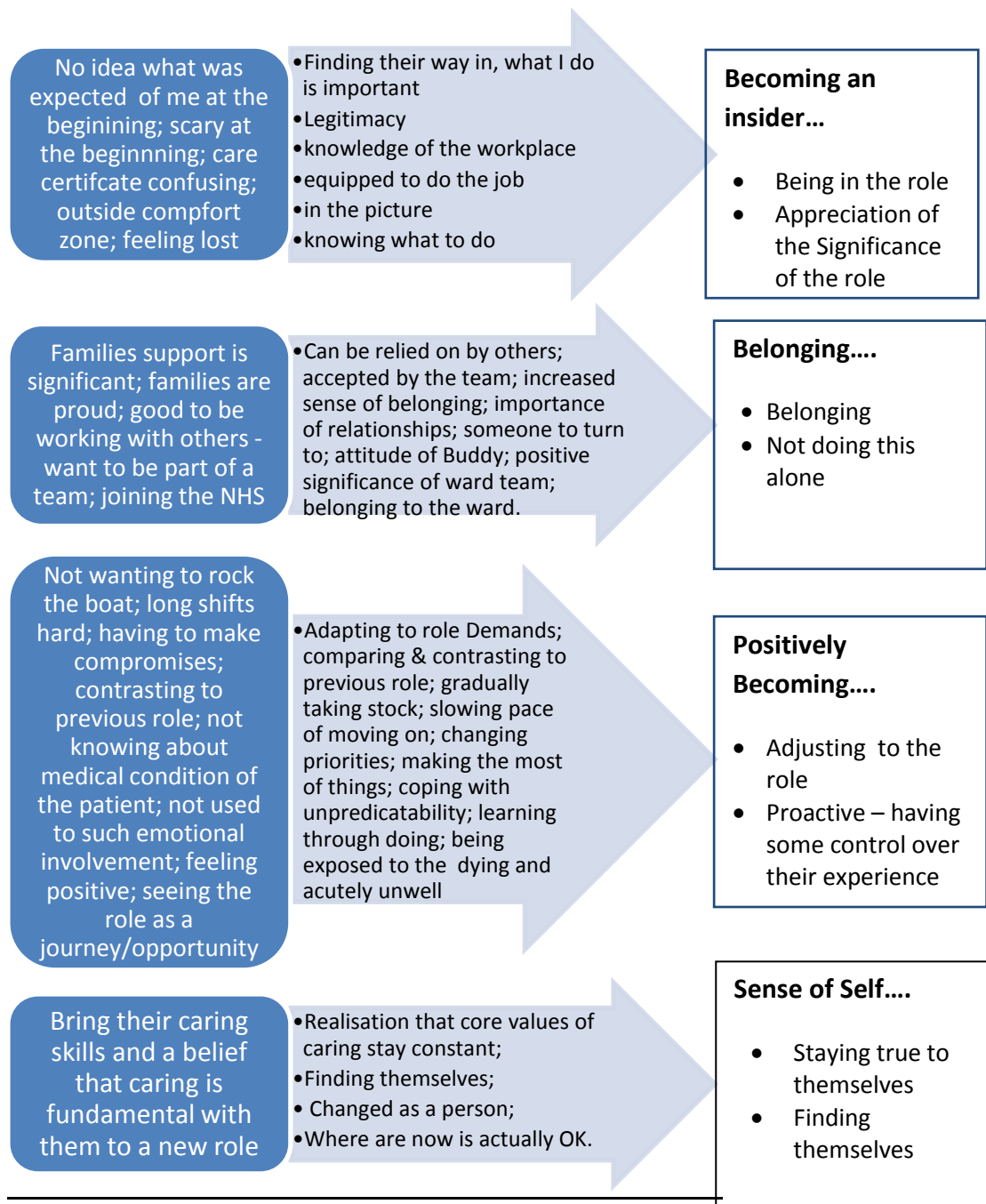
From the analysis of the two sets of interviews and the interpretation of the overarching themes from across the two interviews, it can be seen that there were clear key themes consistently emerging from the data. There was inevitably some cross over and overlap between the themes, with most of the descriptive themes having resonance across both sets of interviews and only themes that were specifically related to the decision to apply for the role and the supernumerary two week initial period on the ward (which were a feature of the first interviews) falling outside of this (see Appendix 22). It could be said that the identified themes accurately represented the voices of the participants in this study (as heard by the researcher) that formed the lived experience in the first six months as HCAs in acute care. These themes were formed into 4 overarching themes that captured the experience over the six months as illustrated in Table 6.3

Figure 6.1 gives a visual representation of the experiences of the study HCAs interpreted through the further exploration of the interview themes as described in this chapter.

Table 6.3. Identification of 4 key themes for the lived experience of the participating HCAs

Overarching Theme	Key overarching themes
Becoming an Insider	<div>Becoming an insider</div>
Belonging	
Being in the Role	
Appreciation of the Significance of the role	
Not doing this alone	<div>Belonging</div>
Staying true to themselves.	<div>Positively Becoming</div>
Finding themselves	
Proactive	<div>A Sense of Self</div>
Adjusting to the role	

Figure 6.1 The lived experiences over the 6 month period



6.4. Personal perspective

Producing a comprehensive account of the findings in a way that represented the true voices of the participants was more time consuming than expected and it felt quite a responsibility to do justice to the HCAs who had taken the time to talk to me. Undertaking an analysis of the themes that were consistent and those that evolved throughout the interviews was an additional step, but I felt that this provided another way for the voices of the participants to be heard. In the end there was a consistency and a thread of concepts that ran within and between the two sets of interviews. Sitting with the HCAs as they gave their accounts certainly highlighted the significance of the experience for many of them as they told their stories with openness and enthusiasm. Some of the themes were not those that I had anticipated based on my previous experience working as an HCA prior to starting my nurse training and through many years of working with HCAs. The significance of the patient's medical condition to the experience and the proactivity of the HCAs were two of these. The interviews provided a wealth of information and it was challenging to synthesise it all into a manageable format. However, it seemed that the interviews could be legitimately summarised through four key themes identified in the chapter and that therefore in the end I felt that the research process had done justice to the HCAs experiences.

6.5. Linking the study findings to the nursing literature

The goal of interpretative hermeneutic inquiry is to enter another's world and identify the participant's meaning of a phenomenon from the blend of what they say about the phenomena in question and the researchers understanding of the situation (Matua and Van Der Wal 2015). In relation to this study and the researchers understanding, it is of significance that the literature of potential relevance to the findings was not read in detail prior to conducting the interviews and analysing the transcripts. In particular, although the methodology sections of some relevant literature was reviewed in order to inform earlier chapters, the findings, conclusion and discussion sections were not. This was in order that the generation of knowledge around the phenomena being studied would come predominately from the voices of the participants (Snelgrove 2014). This is discussed in more detail in Chapter 2. At this point the understanding of the researcher was developed beyond the study findings through returning to the relevant literature and reading it in more detail to become appraised of the ideas of others. This was to explore how the participant's experiences interfaced with existing knowledge pertaining to the experience of commencing a role within a nursing care situation. The focus of the literature was nursing and this was justified as the study was set in the field of nursing. In the main the literature was taken from work with student nurses as it was felt that they had the most in common with HCAs in the absence of any work with HCAs specifically. However, the fact there was limited literature on the experience of HCAs was borne in mind and it was always intended to explore literature from other areas of work and other disciplines at a later stage.

This chapter therefore builds on the previous one which presented the findings from the two time frames of the study independently. Each of the four key themes identified earlier in this chapter are now discussed from the perspective of the participating HCAs first six months in post (rather than for two specific times within that period). Each theme is presented as a blend of the participant's experiences and an interpretation of the relevant literature in order to broaden understanding of the phenomena being discussed.

This section of the chapter is presented under the following headings.

- **Becoming an insider**
- **Belonging**
- **Positively Becoming**
- **A Sense of Self**

6.5.1. Becoming an insider

It felt that this was a main theme of the study as many of the descriptive and Interpretative themes from the analysis of the interviews fell under this broad heading and came across powerfully when reading the transcripts. This included the experiences of those who felt they were very much lost and on the outside looking in at the beginning, surrounded by confusion, and feeling a fraud. Over the six months this evolved into an understanding of what was expected and getting on with it whilst gaining inside knowledge of the language, organisation and workings of their ward, including a greater understanding of the significance of the medical condition of the patients they were caring for. By the six month interview there was a feeling of being in a good place within their wards with the HCAs giving accounts that positively affirmed the position they found themselves in.

Some nursing studies have produced findings that echo the theme of becoming an insider. Fishers (1998) longitudinal study of graduate nurses in their first six months as a staff nurse defined this time of change as the process by which individuals outside an organisation become fully adjusted insiders.

The HCAs at 3-4 weeks talked about initially standing back and being afraid to touch things in case they did something wrong. They were not sure how to behave in a new situation; they did not know the rules; they did not know the language and they were not ready to engage in the realities of the role. Others have found similar experiences in novice student nurses. Kleehammer, Hart and Keck (1990) found that a fear of making mistakes was the most significant source of anxiety in student nurses who were on their first placement. Others

have identified a fear of harming a patient (Kevin 2006, Ross and Clifford 2002) and of avoiding doing things due to a fear of doing them wrong (Tatano Beck 1993), as being significant for those newly exposed to working with patients. The HCAs in this study at 3-4 weeks admitted to being confused and bewildered on their first few days on the ward. Such feelings of confusion and disorientation have been found by others looking at nurses in new situations (Gerrish (2000), Boychuck Duchlsher (2008). Being on the ward for the first few days was seen as frightening for several of the HCAs who used the word 'scary' to describe how they felt. In other work with HCAs, Schneider and colleagues (2010) spent three months immersing themselves in a environment as HCAs caring for patients with dementia for their research. Their reflective diaries indicated the new environment was initially 'somewhat frightening' which they interpreted as being due to unfamiliarity and uncertainty.

An interpretative theme from the initial interview was the HCAs feeling that they did not have a legitimate right to be **in** the HCA role and that they felt a fraud being in the ward situation where patients assumed they were 'real' HCAs. They felt they were pretending to be something they were not. A descriptive indicator of this was the way that they felt like impostors wearing the HCA uniform. This could be linked to feelings of inadequacy and helplessness which have been identified in studies of newly qualified nurses (Higgins et al 2010, Mooney 2007). The significance of the uniform was reiterated in a 2015 study of new student nurses undertaken by Ostrogorsky and colleagues (Ostrogorsky et al 2015) who found that initially the students focused on the external trappings of looking like a nurse as (according to the study authors), they had little concept of what it was to actually be a nurse. Davis (1975) working with new staff nurses, identified an initial incongruity when there was a feeling of hypocrisy and role illegitimacy. The new recruit was likened to an actor feeling a sense of inauthenticity and a lack of conviction about his performance.

Gradually becoming aware of how things were done, what things were called – the language of the work place- and how things worked, largely through

learning by doing, were ways that the HCAs appeared to move from feeling lost to finding a sense of legitimacy inside the workplace. They gradually learnt how to behave in their new working environment. Gerrish (2000) used the term 'fumbling along' to describe the early transition experience of newly qualified nurses and this sits with the descriptions of the HCAs who were finding their way in the first few months. Melia (1987), in her work on the occupational socialisation of student nurses, identified a category of 'learning the rules' which had to do with how student nurses had to 'pass' as workers to the satisfaction of the permanent staff.

At 3-4 weeks the HCAs who took part in the study felt a perceived need to learn what were seen as the skills of the job- the discrete tasks that needed to be done on a shift. An early emphasis on skills acquisition has been found by nurse researchers exploring the experiences of nurses in new roles (Duchscher 2008, Meleis et al 2000). Looking back over their first six months, the HCAs in the study acknowledged that they had learnt most by doing, but at this time frame the perceived emphasis on needing to learn how to do things had diminished, with participants now reporting that they were being allowed to get on with the job and trusted to work independently. As a result of this they were now feeling well placed inside their role, more confident in the demands of the role and in less of a hurry to acquire more skills. This link between acquiring skills and confidence has also been found in new nursing students (Bjorkstrom et al 2008, Fagerberg and Ekman 1998). The term 'know how' was one of the two main concepts found by Arrowsmith (2016) in her literature review of transition in nursing and was concerned with applying the skills of the role with competence and confidence.

6.5.2. Belonging

There are close relationships between the theme of becoming an insider and that of belonging- but it is possible to be 'inside' a place or role and not feel a sense of belonging. Personal experiences of being an undergraduate student

nurse confirm this. The participants also tended to talk about the concepts differently.

The work of Levitt-Jones and colleagues on staff student relationships in nursing (Levitt- Jones et al 2009) led them to conclude that belonging is a deeply personal and contextually mediated experience that evolves in response to the degree to which the individual feel secure, accepted included valued and respected by a defined group. The HCAs new to working in acute care in this study shared experiences that affirmed this. Over the six month period of the study the HCAs moved towards feeling that they were accepted and that they belonged. This sense of feeling a sense of belonging to a defined group has been identified as being particularly important to individuals in studies that have explored the experiences of student nurses (Brown 2004, Chesser- Smyth 2005, Levitt-Jones et al 2008, Papp et al 2003, Secrest et al 2003). The HCAs in acute care participating in this study, expressed a sense of belonging to the ward team at the six month interview as opposed to 'joining the NHS' at the earlier interview. This being part of a team of known individuals was found to be significant in Schneiders (2010) study of HCAs working in mental health units contributing to the wellbeing of team members and a collective identity. The team as a concept was shown to have a symbolic importance from which staff drew pride and protection, job satisfaction and a sense of wellbeing. There is strong evidence that interpersonal relationships are important to how the HCA role functions (Munn et al 2013) which echoed with the voices from the present study where the HCAs shared stories of making friends with colleagues in the team and being included in social events outside of the work environment. Several identified that feeling that they belonged to a team was the most positive aspect of their experience over the six months of the study.

Developing a sense of belonging over the six months was not merely a passive process, or solely dependent on the individual's perceptions of the role and growing in confidence. It also required a degree of becoming a member of the ward team through acceptance by others. The members of the ward team were

influential in enabling the sense of belonging to occur. Key to this was the relationships that the HCAs had with their peers and the ward nursing team. Becoming a valued member of the team, and being known and accepted for who they were, was important to the HCAs in the study. These factors have been identified as an important factor in the nursing literature and are facilitated by accepting responsibilities and being trusted by the team (Bisholt 2012, Schumaker and Meleis 1994, Walker 1998). Key to this was constructive feedback and positive affirmation which have been identified as significant for a positive experience of starting a new role within a new team (Chesser- Smyth and Tong 2012, Deasey et al 2011). The relationship with the Buddy, (particularly the attitude of the Buddy) was significant for the study HCAs. The significance of a named individual, a mentor, has been found to be important in many studies of student nurses (Andrews and Roberts 2003, Papastavrou et al 2010, Saarikoski et al 2007), with the personal characteristics of this individual being instrumental to the success of the role (Andrews 1999). The ward sister role is hierarchically some distance from that of the HCA, yet the ward sister came through as a positive influence on the HCAs experience, particularly when the ward sister was seen to make time to spend with them as individuals, a finding echoed in work with student nurses (Brown 2004).

There was a clear sense that the HCAs were not going through the experience alone and had significant support outside of work. Family members, as well as the ward team, were of significance for their support and practical help, particularly at the beginning of the experience at the start of the new role. The importance of key relationships providing support that is integral to the transition process has been highlighted in several nursing studies (Arman and Rehnsfeldt 2003, Kralik et al 2006, Shloessler and Waldo 2006).

6.5.3. Positively Becoming

This theme involved adjustment to the role through the study participants taking an active part in becoming an HCA in acute care. In a sense it builds on the previous theme as the HCAs were able to become what they were in their role through being able to move from outside to inside the role and in feeling that

they belonged. Others have also made the link between a feeling of belonging and the capacity to be proactive, including Watson's study of preregistration nursing students' experiences of mentorship (Watson 1999). .

Over the six months there was progression from passivity to proactively and from standing back to engagement. This emerged as a key theme through seeing the HCAs in the study rising to the challenges of the role and actively seeking out and creating opportunities for learning in the role. The participating HCAs seemed to be working out the structure of their working environment and negotiating the best way to work within it. There was a sense that they were doing this on their own as all the participating HCAs were on their own as new starters on their wards. They were identifying ways to make the working day more of a positive experience for themselves through choosing who they turned to for help and whose instructions, advice and feedback they took most to heart. Some had realised that the rules they had tried so hard to grasp at the beginning were not consistent, being interpreted differently by different members of the team. This is a theme that has been identified with student nurses, with rule bending being seen as a necessary part of organisational socialisation (Meleis 1984).

The study HCAs were actively looking to identify boundaries between their role and that of others in the team, realising that sometimes these were blurred and working out if, and when, these boundaries could be crossed. There was a sense of having some control over the pace of movement of the experience of moving into their new role transition and the feeling of being on a journey. The HCAs were facing the day to day realities of the role, including the unpredictability and uncertainties with a sense of positivity and realism, even though some days and experiences were still challenging. The significance of the role, in some cases the enormity of what they were able to be a part of, alongside the specifics of the patient case load, particularly in terms of the patient's medical condition, was a new concept for most. The HCAs had realised that they would need to make certain sacrifices in their personal and

family lives for the greater good of making the role work for them but, on the whole they had worked this out and adapted to it by the six month interview. They adapted well to the things over which they had some control and where there were workable solutions to problems. The HCAs were making particular changes around child care arrangements and reorganising their lives around the demands of shift patterns which for some meant working nights and weekends for the first time. There was an acceptance by the HCAs that this was part of being in the role and that they were making sacrifices for the greater good. The exception to this being the twelve hour shifts which were challenging for many, and impossible for some. Two had adapted their role in terms of changing ward and reducing hours by the six month interview. Central to this key theme for the study is the concept of adapting to becoming an HCA in acute care through proactively engaging with the process and meeting challenges head on. Several nursing research studies have also identified a similar theme. Brown and Olshansky (1997) in a study of experienced nurses becoming specialist nurses identified a theme of 'meeting the challenge as being important'. Newton and McKenna (2007) in a study of newly qualified nurses identified a theme of 'surviving' through adopting various tactics. Actively stepping out of a comfort zone has been identified as important part of the adjustment to a new role (Cubit and Lopez 2012). Melias work with student nurses (Melia 1987) identified that many fostered a proactive view, with individuals 'fitting in' and 'getting through'.

The six month duration of the study was particularly one of adapting to the realities of the role. At six months the HCAs were adapting to coping with the physical and emotional aspects and needing to care for unwell and medically unstable patients in an acute hospital setting. This was voiced as a significant factor for many of the HCAs who in the first interview gave vivid accounts of being on duty when there was an unwell or unstable patient and describing how this made feel unprepared and inadequate. This feeling was something they were not expecting, particularly those who had worked in a caring capacity previously where patients were more stable and where (for some working in the

community) they might only be with the patients for short periods of time. The emotional aspect of caring for acutely unwell patients is recognised to be a significant factor for the experience student nurses (O' Donnell 2008) and was significant factor for the participating HCAs. This was both in terms of engaging with patient whilst at work but also thinking about the patients when they were off duty. Emotional consequences have been identified by others exploring the experience of nurse new to roles as having disruptive influence on the experience (Duchscher 2008 O' Donnell 2008). However, this seemed to be something that the HCAs were talking through with key members of the team, and sometimes with family members, and whilst it was identified as being difficult for some at 3-4 weeks it was not seen as an on-going problem or something that they could not cope with after six months.

The HCAs in the study were actively exploring the differences between their role and that of the registered nurse, and most saw this hierarchical relationship in a positive light, although there were some who questioned the differences in what they and the registered nurses were doing on particular shifts. For most of the participants, this was the first time they had worked with registered nurses on a day to day basis and they could identify inconsistencies in how the two roles worked together. This blurring of role boundaries has been found in other studies looking at the HCA role in acute care (Alcorn and Topping 2009, Workman 1996). Schneider et al 2010 in their work with HCAs caring for those with dementia observed what they termed a subtlety of the line that HCAs drew between themselves and nurses. Blurring of role boundaries was one of the codes identified in the review of nurses experiences in role transition (Arrowsmith et al 2016) and has been identified in studies exploring the transition experience of inexperienced 'novice' nurses (Etheridge 2007, Ross and Clifford 2002, Rungapadiarchy et al 2006). It is of note that at six months the expressed desire of many of the HCAs to become a registered nurse was tempered in terms of both enthusiasm and timescales. There was a sense that where they were at six months was where they needed to stay for a while, with

some now expressing that they no longer felt the same initial impetus to become a registered nurse.

Awareness of the enormity of the role that they were in, the significance of what they were doing, for example it not 'being like jobs in retail' was significant and particularly so if this had not fully anticipated. An appreciation of what it meant to be caring for critically ill patients, particularly those who were dying, was for many something they had not really considered and it was seen as a significant difference in role for those who had previously worked as cares in the community. Butler-Williams et al (2010) in their study of HCAs in district general hospitals found that those who were exposed to caring for acutely unwell patients reported that this could be stressful. Those studying the experiences of student nurses have also found the medical condition of the patient to be a significant challenge once the implications for caring for these patients had hit home (Cooke 1996). Others have reported that certain types of patients, for example the dying, the seriously ill or those patients that were deemed difficult to care for were a challenge (Kleehammer et al 1990, Sellek 1982). The participating HCAs felt ill prepared for caring for patients in a more clinical environment that they had previously worked in. They felt they needed to know more about the medical background of the patients and how this impacted on their care. There was a sense that patients needed more 'things doing' and the HCAs felt that they didn't always know what these things were. This links with the work of Brennan and McSherry (2008) who studied student nurses who had been HCAs. These students reported an inability to apply their existing knowledge to the hospital environment due to the faster pace and differing routines. Ultimately, most of the study HCAs at six months saw this aspect of their role as a challenge that they were proud to have met and saw it as affirming the importance of the role they felt they were now performing well. They chose to recount examples of when their involvement with a sick patient had made a difference to the patient's outcome.

The examples of positive adjustment, rising to challenges and creating situations to maximise learning are components of a theme of positive becoming. Many of the HCAs at the time of the first interview reported being excited on the first day, something that has been reported with studies of novice nurses. Duchscher (2008) reported feelings of excitement and exhilaration, but deemed these to be overshadowed by overwhelming negative emotions. This negativity was not found in this study with HCAs who demonstrated positively throughout their interviews. Demonstrating a positive outlook, sometimes termed positive framing, has been linked to successful role change in nursing (Melies and Schumacher 2006). There is also evidence that newcomer personality can have an impact on adjustment during transition with a positive outlook being linked to a more successful outcome (Wanberg and Kammeyer-Mueller 2000).

6.5.4. A sense of self

For the HCAs in this study, this theme focused on a sense of who they were, and was a result of introspection and self analysis. Several participants experienced a sense of personal growth within themselves that was also observed by those around them. This focus on self was in contrast to much of the experience described by the participants that focused on looking outward to external parameters of where they were going, what they were doing, and who they were with. This sense of self was apparent across the study time frame and at six months highlighted that participants were feeling positive about the sense of who they were and more confident in themselves as individuals both in and outside of the work environment. Self as focus has been identified as a common initial response in those new to a role within caring. Brown (2004) in her work with student nurses early in their training identified a sense of self as being pre-eminent and concluded that it reflected students' needs to adapt to the new environment in which they found themselves.

The sense of self for many was the focus on themselves as being first and foremost carers. Caring as a theme for this studies participating HCAs immersed as a key theme largely through the second interviews and the review

of the overarching themes from the two interviews, however, caring was always there in the background, even in the first interviews, as the participants talked about how they identified themselves as carers and how a perceived opportunity to care was a motivational factor in choosing the HCA role. Studies involving the caring professions, in particular health care workers on vocational training (Coley et al 2003), have identified a prevailing ideology linked to the moral rectitude of being nice and doing good, of caring. These authors identified that such individuals often work within a vocational culture that informs how one should properly feel and act as well the values, attitudes and beliefs that one should espouse. A range of authors have reported on the importance of a caring ethos as central to nursing (Kitson 1987, Mackintosh 2006, McCance et al 1997). Lear's (2016) study of HCAs who had been seconded to undertake nurse training found that the study HCAs voiced the importance of values such as caring, compassion, empathy and respecting people's dignity.

All the participants had had experience of caring, indeed this was a requirement in the job specification and would have been part of the short listing criteria for the role. However this theme seemed to be less about caring as an action or something that they did, but rather it was more about caring as linked to intrinsic personal values for the participants, both as individuals and as HCAs. The participants appeared to gain a certain security from a core value of caring when other things seemed less certain. The interviews revealed many instances of participants talking about the significance of caring to them and how it was important that what they did made a difference to the patients. However the examples given of when they felt they had made a difference were often around successfully supporting a deteriorating patient. It seemed that participants were shifting their sense of self towards a more acute care setting and chose to recall situations that affirmed that this was what was happening. .

Trede and Schweri (2014) in their research on the work values of HCAs intending to become student nurses, made the distinction between Intrinsic values, linked directly to the nature of the role i.e. meaningfulness or making good use of ones skills, and extrinsic values associated with the importance

placed on external rewards such as income, career advancement and status. It would seem that the HCAs in this study of transition to a role in acute care were focusing on the intrinsic values. Whilst they appreciated that what they were doing was important work, and had the potential to open doors for further opportunities, there was no sense that income or status impacted significantly (either positively or negatively) on the experience.

6.6. Conclusion

This chapter has brought together the voices of the participants and the nursing literature around the four themes of **becoming an insider, belonging, positively becoming and a sense of self**. It has identified some parity for most of the themes with the experiences of nurses in new roles, particularly student nurses. However, this chapter has looked at themes in isolation, with the literature cited being taken from studies with many different nursing roles and contexts. It has been to some extent a case of finding what was looked for, with anomalies and themes from the literature that fell outside the experience of the study participants not being acknowledged. This is not sufficient conceptual detail on which to build a framework that illustrates the experiences of HCAs in their first six months in a role within an acute care environment. The next chapter aims to facilitate this through examining in more detail the conceptual underpinnings around the knowledge and understanding of the experience of starting in a new role; firstly from a nursing perspective, and subsequently through literature taken from wider afield.

7. Discussion

7.1. Introduction

The previous chapter has involved reviewing the nursing literature in more detail than was undertaken at the start of the study (Chapter 2) and this has highlighted how the experience of individuals entering new roles within nursing interfaces with the findings of the study. This involved marrying themes drawn from the experiences of the HCAs with corresponding themes from nursing studies and did not allow for the emergence of a framework for the overall experience of the HCAs new to a role in acute care. This next chapter aims to go beyond this by suggesting a way that draws together the key themes from this study (formed the voices of the participants) into a cohesive conceptual framework.

The aim of this discussion is to allow judgement as to how the lived experience of the HCAs who participated in this study sits within existing frameworks of the experience of starting a new role. It will also provide a vehicle for how the findings from this study can be conceptualised for readers who may want to use them to inform practice.

The chapter starts by returning to the concept of transition in nursing that was first discussed in Chapter 2; and discusses how this in part, but not completely, relates to the voices of the study participants.

The chapter then explores the wider literature on starting a new role, and highlights the literature around becoming an insider, newcomer adjustment and the proactive newcomer, which has resonance with the themes voiced by the study participants and has a link to organisational socialisation, a concept that was introduced briefly in Chapter 2. This leads to the concepts of proximal participation and legitimate peripheral participation which have developed largely through the study of apprenticeship and Newcomer Adjustment. The chapter outlines the thought process behind the final conceptual framework for the lived experiences of HCAs in their first six months in post in an acute care.

7.2 Transition in nursing

Transition as a concept has been used in much of the literature reviewed thus far and was the concept thought to resonate most closely with the study in its early stages as discussed in Chapter 2. Indeed, the first draft of the research question was framed around exploring the experiences of HCAs in their *transition* to a new role. Theories of transition are in agreement that it involves movement from one state to another; is prompted by change and that it is characterised by stages of change which take place over time (Arrowsmith 2016). It has links to the concept of professional socialisation outlined in chapter 2. Two significant writers on transition in nursing are Meleis and Boychuk Duchscher whose work is outlined below.

7.2.1. Meleis' middle range theory of Transition

Afaf Meleis, a prominent nurse sociologist built up her theory over many years with an initial focus on symbolic interactionism and its role in responses during transition. In her early work with nurses she explored ineffective transitions in relation to role insufficiency and identified how nurses could develop role supplementation strategies as therapeutic support for individuals experiencing transition (Meleis and Swendon 1978). Her middle range theory of transitions (Schumacher and Meleis 1994, Meleis et al 2000) has been widely used in nursing studies. There are major assumptions of this transition theory which include (Im 2013).

- Transitions are complex and multidimensional with patterns of multiplicity and complexity characterised by flow and movement over time
- Transition causes changes in identities, roles, relationships, abilities, patterns of behaviours and fundamental life patterns.
- The daily lives of clients, environments and interactions are shaped by the nature, conditions, meanings and processes of their transition experience

- Vulnerability is related to transition experiences that expose individuals to potential damage, problematic or extended recovery or unhealthy coping.

This theory is classed as middle range in that it sits between the minor working hypotheses of everyday life and all-inclusive grand theories (Arrowsmith 2016). It has assumptions that potentially map across to the themes from the study of HCAs new to acute care; for example the concept of identity change. As a middle range theory, as opposed to a situation specific theory, it has limitations in scope and abstraction (Im 2013). It felt too broad to resonate with the key themes of a specific study of the experiences of HCAs and it seemed that certain key components of the lived experiences of the participating HCAs were not championed by this theory. This was particularly the case of the concept of **becoming an insider**.

7.2.2. Boychuck Duchschers' theory of becoming a professional nurse

Boychuk Duchscher's theory of transition (2008) was based on a process of becoming a professional nurse and was informed through ten years of studying new graduate nurses who were seen to progress through the stages of doing, being and knowing over a twelve month period. Much of the evidence that informed this theory came from nurses working in acute care and so has potential links to a study with HCAs new to working in acute care. This theory saw transition as a journey made up of ordered processes that include anticipation, learning, performing, concealing, adjusting, questioning, revealing, separating, rediscovering, exploring and engaging. It had links to Kramers' work (Kramer 1974) on transition shock where an initial honeymoon phase gives way to a shocking insult on professional values that leaves individuals disorientated and disillusioned before reaching a recovery and resolution phase. This theory of transition has some resonance with the HCAs moving into an acute care environment in that there is an early focus on doing and being that formed part of the interpretative themes from the first interviews at 3-4 weeks. However Boychuck Duchscher's theory is specifically for registered nurses in a professional role and so it is unlikely that it would transfer directly to the

experience of HCAs. At three months this theory focuses on the graduate nurses adjusting to the differences between the theoretical aspects of their education and the realities of the workplace, a concept which is outside the scope of the HCAs in a new role in acute care who had no syllabus to follow; no formal education for their role and no academic or professional end point. Certainly the themes around shock and crisis, which form a significant part of this model of transition, fall outside the experiences of the HCAs in this study starting a new role in an acute care environment.

7.2.3. The concept of Transition to illuminate the experiences of the study HCAs

From exploring the literature on transition in nursing it can be seen that the themes identified from the voices of the study participants: **positively becoming a sense of self** and to some extent **belonging** have a link to the concept of transition in nursing. This is highlighted in the paragraphs below. The theme of becoming **an insider** sits less well with this concept and this prompted the search of the wider literature that is explored in the second half of this chapter.

7.2.3.1. Positively becoming

In their review of transition in the health care literature, Kralik et al (2006) made the point that transition requires the individual to acknowledge that change needs to occur before the transition process can begin. They described transition as a time during which people redevelop self-agency in response to the events that have brought about the need for transition (van Loon & Kralik 2005). It is then possible to make sense of what is happening and reorganise a new way to respond and to be in the world (Kralik et al 2006). Melieis et al (2000) writing about transition in nursing, referred to this as surfacing awareness. This fits with the HCAs in the study who were making sense of the role through being part of it (**belonging**) and seeing how they as individuals fitted in with the roles of those that they were working with. Alongside this, they were developing and enacting strategies to become what they thought the role required through proactive engagement. Meleis et al (2000) considered that, for

transition to occur, the individual needs to be able to reflect and then interact and through this develop increasing confidence in the change. This suggests the requirement for a degree of (pro) activity on behalf of the individual experiencing the transition Chick and Meleis (1986), again writing about transition from a nursing viewpoint, considered that in transition, an initial growing awareness of the role is followed by a gradual engagement, where the person is immersed in the transition process and undertakes activities such as seeking out information, feedback and support. The HCAs in this study were working out the strengths and weaknesses of the team and proactively seeking out those from whom they thought they would learn the most.

Studies that have looked at transition to nursing have used the term Reality Shock or Transition Shock (Boychuck Duchscher 2009, Kramer 1974) to describe this stage which in transition when reality hits home. Day et al (2005) in a study of student nurses in their first few weeks identified a move from idealism to realism. It is a stage that is often portrayed negatively. Houghton (2014) in her work around student nurses as newcomers, explored the concept of pre entry knowledge and concluded that knowing what to expect helps the transition into a new role by helping newcomers understand what is expected of them. Schumaker and Meleis (1994) in their paper on transitions in nursing suggested that expectations are key subjective phenomena that collectively influence the transition experience. The HCAs taking part in this study had tended not to look into the practicalities of the role before they applied and so had come into the role without set expectations around the reality of the role. It was as if having a limited sense of the reality of the role before they started protected them from reality shock once they were in post. Whilst the sample of HCAs in this study seemed to see the day to day reality of their role as a challenge, it was seen as one that, though hard work, (and with more knowledge about the patient's medical condition), was a challenge they felt that they could meet. The concept of transition shock did not really resonate with this group. At six months they chose to present themselves as feeling assured and positive about the work that they were doing.

7.2.3.2. Belonging.

The concept of transition could be considered to be about the process of getting to the point of belonging to a role. Within nursing, it has been used to study the process of belonging to the professional role of registered nurse (Arrowsmith et al 2016). The study HCAs (non-professionals) were looking at how the work they did on the ward compared and contrasted with that of others, particularly the registered nurses (professionals). This tended to occur on an individual basis with participants comparing what they did with the work of particular others on particular occasions. It was not so much a comparison of roles but of individuals within the roles. At the beginning, in the first interview, there was a sense of not belonging to the role of HCA through feeling a fraud in the uniform and not knowing how to do things. This did not particularly translate to a feeling of being an HCA in the second interview; at this point it was more about feeling able to perform a specific role within their particular ward and of being recognised as being able to do this as an individual i.e. of belonging to the role as it applied to them- a clear sense of belonging to their role on a day to day basis (rather than belonging to the role of an HCA or indeed being an HCA). There was no arrival point of belonging in the wider HCA role as such, and no obvious affinity with belonging to a peer group alongside fellow HCAs. Participants did not refer to themselves as HCAs, but rather as individuals performing a particular role in a particular ward. There was a brief period in the first few weeks when the HCAs felt they belonged to the HCA induction group- but this soon dissipated and this group was not significant to them at six months. There was an allegiance to what being in the role allowed them to do and a sense of personal belonging to their particular job role- a personal sense of fit, rather than a collective affiliation. The key affinity and sense of belonging was with the ward team, a disparate group made up of many roles. For several of the HCAs in the study this was the most significant part of the six month experience. Studies using transition as a concept have tended to focus on individuals gaining a sense of belonging to a clearly defined peer group, and so transition as a theoretical concept has its limitations with the experiences of the study HCAs.

7.2.3.3. Sense of self

Following on from above, the study HCAs were experiencing a heightened awareness of who they were in relation to the world of work and who they were as individuals. There was a sense of becoming more able to do what was required of the role and in a sense becoming 'more themselves' through this. Sense of self has been identified as being intrinsic to the experience of transition through facilitating a process of reconstruction or change within the individual (Beach 1999, Crafter and Maunder 2012). Work role transition is said to involve identity change as new values immerge when individuals search for new meaning to match situational demands (Nicholson 1984).

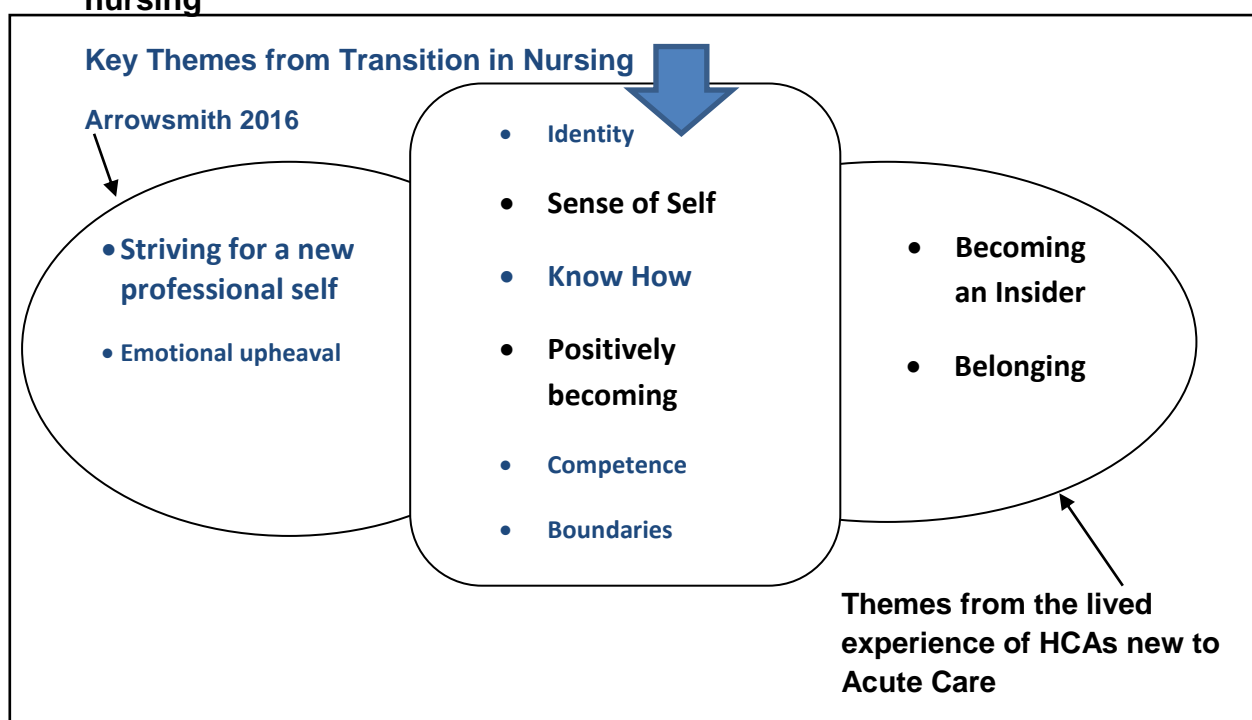
In their literature of review of transition in health care, Kralik et al (2006) defined transition as a process of convoluted passages during which people redefine their sense of self. They concluded that reconstruction of a valued self-identity and a heightened awareness of self are essential to transition and that transition is a time of inner re-orientation and/or transformation (Kralik et al 2003). In their review of nurses perceptions and experiences of role transitions (Arrowsmith et al 2016) considered identity to be one of the main analytical themes identified from a comprehensive review of the literature. They identified several studies where identity was highlighted as a theme in the findings around transition. This included the work of Bjorkstrom et al 2006, Holt 2008, Kapborg and Fischbein 1998. These studies identified gaining a new identity through a change in role as a key experience of transition. Holt (2008) in a study of role transition in primary care concluded that identity was regarded as being: the role, the person and being part of a group. Changes in identity have also been associated with changes to attitudes and values as nurses undergo change (Dearnley 2006, Melrose and Gordon 2011). Most of these studies focused on the concept of *professional* identity as nurses took on new roles within the profession of nursing. The HCAs participating in this study were more concerned with their identity as individuals and so the concept of self-identity and identity as a person is potentially of more relevance here. It has been said that individuals learn ways to adapt to change through a heightened awareness of self (Fraser 1999, Kralik et al 2003). Self-identity and a sense of self has been found to

have a positive link to a positive experience of transition, particularly around feeling trusted and recognised (Chesser- Smyth and Tong 2012). Self-awareness (sense of self) was identified as a significant concept in Chesser-Smyths 2005 study with student nurses in their first clinical placement. Self as focus has been identified as being representative of an initial emphasis on concentrating effort and attention the senses of security and belonging for student nurses in clinical placements (Brown et al 2008). This concept links the study themes of sense of self and sense of belonging.

7.2.4. Transition as a theoretical framework for the study

Having looked at the theories of transition in nursing, it became apparent that the experiences of the HCAs in the study had some resonance transition as a concept. Arrowsmith (2016) in her review of transition in nursing which looked at twenty six research papers on nursing work role transition, concluded that the analytical themes of ‘striving for a new professional self’ and ‘know how’ ; with their associated descriptive themes (emotional upheaval, identity, competence and role boundaries) are found across the research on role transitions. The diagram below (Figure 7.1) aims to illustrate how these concepts map, (or do not map), across to the experiences of the study HCAs.

Figure 7.1 The lived experience in relation to the theory of Transition in nursing



It can be seen that whilst there is some cross over to the experiences of the study HCAs, the concept of transition, as identified in the literature reviews above, is not representative of the full lived experience of HCAs in a new role in acute care. One reason for this is possibly because much of the research in which the concept of transition has been built is based on the experiences of student nurses making the transition to registered nurse. Much of the literature on transition in nursing makes reference to the concept of professional socialisation (Arrowsmith et al 2016), which was outlined as a concept in chapter 2, and will by its very nature, have a bias towards the study of individuals moving within and between professional roles. Student nurses differ from newly appointed HCAs in their initial exposure to their role. They occupy a transient position moving from ward to ward, a state that has been described as 'just passing through' (Melia 1987). Student nurses spend time in the clinical areas and therefore experience being a newcomer in each clinical placement, but at the start of each placement they know that the experience will be finite. They also have clear learning objectives for each placement. Student nurses also differ from HCAs in that they have an end point- that of registered nurse; and defined milestones and timescales to achieve this. Student nurses also experience their movement into a new role through allegiance to a cohort of other student nurses and an academic institution rather than a ward. It is therefore not surprising that transition as a concept, as described in the nursing literature, does not apply fully to the experience of the study HCAs.

7.3. A personal perspective

I had thought, in hindsight somewhat naively, that it would be possible to match the key findings of the study with an existing theory of transition and then spend time discussing the key concepts of this theory in relation to the experiences of the HCAs who took part in the study. However it became apparent that the idea of basing the study around the idea of Transition in nursing was flawed. Transition theories have been built up from the study of registered nurses and not all the themes from the voices of the participants resonated with this concept particularly that of becoming an insider and the strong sense of belonging to the ward. After further literature searches around roles that were thought to potentially have similarity with the HCAs ranging from physiotherapy and occupational therapy assistants to cabin crew, it became clear that ideas

around apprenticeship were of more relevance and warranted further exploration.

7.4. Beyond the world of transition in nursing - beyond the world of nursing.

Whilst not all studies of the experiences of nurses new to a role have used the concept of transition (Brown et al 2008 a,b; Chesser Smyth 2005, Day et al 2005, Houghton 2014), the idea was emerging that there were key aspects of the lived experiences of the study HCAs that sat outside the world of nursing. Therefore, the wider literature was next examined to explore knowledge of the experiences of those new to roles beyond the world of nursing. The key themes from the study **becoming an insider, belonging, positively becoming** and a **sense of self** are each explored below in relation to the identified literature.

7.4.1. Becoming an insider

In terms of the number of descriptive themes and the general interpretative feel of the interviews, this felt like the dominant theme of the study and as such is potentially the one that needs to resonate most with any existing theory that subsequently becomes part of a framework for the experiences of HCAs new to acute care. The concept of moving from organisational outsiders to insiders is central to much of the literature on organisational socialisation (Bauer et al 2007) and this part of the discussion was informed by reading around the literature that focused on becoming an insider as a main concept. At this point there was a conscious effort to move the emphasis away from the experiences of those employed in professional roles or in a student capacity. This was because, as highlighted earlier in this chapter, the literature around the experiences of those undergoing transition in nursing (a profession), only partly fitted with the key themes of the study. This led to reading literature that focused on becoming an insider in a range of situations. One of the first of these was the work of Hundeide (2003) who explored the concept of becoming a committed insider in a non-employment situation (counter- culture youth groups). The concept of social participation as a way of being a member of a group of like-

mindful individuals was explored as were models of apprenticeship as a way of becoming. On the surface this had limited value to a study with HCAs, but it introduced the concept of becoming a skilled insider in a range of traditional roles through a wider process of participation in a community of practice and informal tacit socialisation as part of a model of apprenticeship. A key theory presented here, the model of legitimate peripheral participation (Lave & Wenger, 1991), where the apprentice passes through stages from periphery to centre to become 'a full member' or an insider resonated with the experiences of the HCAs in the study. The notion that the HCAs were likely to be having experiences more akin to apprentices 'learning on the job', rather than those becoming professionals through structured periods of study away from the clinical environment, began to have a resonance. The concept of apprenticeship in relation to the study is now explored further.

7.4.1.1. The concept of apprenticeship

The term apprenticeship has been used as a term to describe both a concept and a particular role (Lave and Wenger 1991). The hallmark trait of an apprentice is said to be the immersion in an environment that, whilst facilitating practical know how, also structures the acquisition of social knowledge, world views and moral principles that denote membership and status in a role (Marchland 2008). The opportunities for learning through apprenticeship range from opportunistic and task orientated with the apprentice doing most of their learning unsupervised, to more formal structured learning leading to recognised (usually vocational) qualifications (Marchland 2008). Apprenticeships have been described using a range of theoretical concepts including behavioural modelling and socialisation theory (Spouse 2004). Four key concepts commonly discussed in the apprenticeship literature are situatedness; guided participation; legitimate peripheral participation and membership in of a community of practice (Dennen and Burner 2008). These concepts have a resonance with the study HCAs whose experience was centred in one place (the ward) which they felt they were being guided to belong to and work within through a process of moving from being outsiders to insiders.

7.4.1.1.2. Apprenticeship in nursing

It has been said (Spouse 1998), that historically, views on how best to prepare nurses have reflected existing ideologies in both education and nursing, which have in turn reflected the prevailing social climate. Nurses were for many years part of an apprentice style of training which fitted with concept of nursing as a skills or craft activity whereby learner nurses, as apprentices, were employed by their place of work under the tight control of the ward sister (Maggs 1983). Early work around the experience of student nurses acknowledged this and used the concept of organisation socialisation to explain how student nurses developed a sense of belonging to each ward in which they were based throughout their training (Melia 1984). The movement of nurse training to the educational establishments of higher education, and the associated student status for nurses in training, had a significant impact on the way in which student nurses learnt and in how they were perceived as a profession (Gray and Smith 1999, Philpin 1999). Recent moves to introduce opportunities for apprenticeship style entry into registered nursing re- introduced the concept of apprenticeship as a way of becoming socialised into nursing (Glasper 2014).

7.4.1.2. Legitimate peripheral participation

To take these emerging ideas forward, and in particular to keep a focus on the study theme of **becoming an insider**, the theory of legitimate peripheral participation, which features in many studies of apprenticeship models (Chan et al 2016, Belcher 1994, Marchand 1994, Richmond and Kurth 1999) was explored. This was done in conjunction with reading situation-specific conceptual frameworks of those taking on a new role through apprenticeship. This was an attempt to bring the theory down to a real life context in order to have parity with this study of twelve HCAs. One example that resonated with the experiences of the HCAs that participated in the study is the experience of apprentice bakers (Chan 2013). This will be discussed later in this chapter and used to inform the diagrammatic representation of experiences of the study HCAs in relation to theory of Legitimate Peripheral Participation within a Community of Practice (Figure 7.2).

Lave and Wenger (1991) explored the development of a social practice or situated theory of learning. Their primary purpose and focus was to conceptualise the way by which new (novice) entrants to a workplace gain the skills, knowledge and habits necessary to become full participants in that work place. This notion was termed- legitimate peripheral participation and it had its roots in the study of apprenticeships (Fuller et al 2005). Lave and Wenger (1991) considered that peripherally, when enabled, creates an opening and a way of gaining access to sources of understanding through growing involvement in the place of work. The theory explained how apprentices become *in bound* and *insiders* as they establish themselves in the workplace and build confidence in the skills of the job. Sayer (2014) considered that this theory of legitimate peripheral participation involves moving in a centripetal direction to become journeymen and then full participants in the workplace which can be defined as a community of practice. Lave and Wenger (1991) saw the act of becoming full participants as embedded in the context in which the individual is co-participating with others and an integral part of generative social practice in the lived in world. The processes, relationships and experiences which constitute the persons sense of belonging underpin the nature and extent of subsequent participation (Fuller et al 2005). Lave (1988) considered that legitimate peripheral participation enables newcomers to enter the world of old-timers: to engage in progressively increasingly complex activities, whilst also developing identity as a member of a community of socio cultural practice with a shared goal. A world which has been termed a community of practice (White 2010).

7.4.1.3. Community of Practice

A community of practice has been defined as group with a purpose (Wheatley 2004) and also as the context in which an individual develops practices (including the norms, values and relationships and identities) appropriate to that community (Handley et al 2006). Lave and Wenger (1994) considered a community of practice to be a requirement for the existence of knowledge within a group as it provides the interpretative support necessary for becoming a full participant in the cultural practices of a community. Learning is seen as a social

activity within that community (Fuller et al 2005). Individuals with a common goal are said to learn how to do the necessary work more effectively through interacting together regularly (Wenger 2011). Newcomers are supported by full participants who enable them to gain access to the community of practice in order to learn (Sayer 2014). As a concept, it is an integral part of the theory of legitimate peripheral participation and features in many papers looking at the experiences of apprenticeship (Wenger 1998). It has also been looked at from a nursing perspective, with the ward being seen as a potential community of practice to facilitate work based learning. (Andrew and Ferguson 2008, Andrew et al 2008, White 2010). It could be said that the HCAs in the study were (unknowingly) entering a community of practice in their ward environment and components of this, as concept, do have a resonance with the voiced experiences of the HCAs participating in the study, mainly the concept of gradually being enabled to move inwards into the community of work through gaining the knowledge and skills from within the workplace in order to become a legitimate member of the community. Certainly the study participants felt that they had learnt most through 'learning on the job' that was facilitated by the supportive actions of the ward team. The notion that outsiders develop practices specifically for the community where they work also fits with the idea that over the six month study time the participating HCAs were experiencing a sense of belonging to their particular ward and their particular role within it.

However the concept of communities of practice may not fully represent the experience of the study HCAs learning in the ward environment. It has been criticised as a concept for being too focused on learning rather than other aspects of adapting or adjusting to a new role in the work context (Sayer 2014), and for not acknowledging the full complexity of the workings of a community of individuals engaged in work related activity (Fuller et al 2005).

7.4.2. Belonging

The theme of belonging has relevance to Lave and Wengers (1991) concept of legitimate peripheral participation. For these authors, the action of participating in social practice was seen as a way of belonging to a community. The theory

holds that it is this membership of a community (belonging) that allows participation and therefore learning to take place i.e. the processes, relationships and experiences which constitute the participants sense of belonging underpin the nature and extent of subsequent learning (Fuller et al 2005). It was important to the HCAs in the study that they were building relationships with the team in which they were working. Throughout the first six months there was a shift in focus from the idea of working for the NHS and the hospital to being part of and belonging to their ward. The impact of a newcomer's reference group has been seen to be more significant than that of the 'psychologically distant' organisation Ashforth and Saks (1996). At six months it was the relationship with the ward team that was seen as the most significant as the study participants left behind the early relationship with peers on the induction programme. It was a sense of belonging to the ward team that gave the participants a feeling of being allowed into the world of work on their ward.

7.4.3. Positively Becoming

The interpretative themes from the lived experiences of the study HCAs that formed the theme of positively becoming, related to individuals developing strategies to adapt to change and to put themselves in the best position to create situations that allowed positive changes to occur. They were acting as proactive newcomers. This has a resonance to the literature around adaptation and in particular newcomer adjustment. A significant study of relevance to this was the work of Houghton, who used ideas from outside the world of nursing to examine how student nurses fit in with the real world of practice (Houghton 2014). Houghton's work introduced the concept of newcomer disposition which led to reading further literature on employee proactively. These concepts have their roots in the world of work outside health care but have a resonance with the experiences of the HCAs in this study and are now outlined.

7.4.3.1. Newcomer disposition

Newcomer disposition has been identified as an important component of the adaptation process (Gruman and Saks 2001, Harrison et al 2011, Morrison 1993). It has a strong link to the study theme of **positively becoming** which captures the proactive nature of the participating HCAs in wanting to get on and fit in to their workplace. Those that proactively seek out information and feedback have been seen to benefit the most from organisational support systems (Bauer et al 2007, Gruman et al 2006, Kammayer and Wanberg 2003, Kim et al 2006). Ashford and Black (1996) considered that it is the gap between individuals motivation for perceived control and the relative uncontrollability of entry situations that provides employees with a motivation for action. The HCAs entering a new role initially described feelings of chaos, bewilderment and disengagement which may have been a motivator for subsequent proactive behaviours over the latter part of the initial six month period. Ashford and Black (1996) discussed three general types of employee proactively: positive framing (interpreting the environment positively), sense making (seeking out information and feedback) and relationship building (general socialising, networking and building relationships). These three types of employee proactively were displayed by the study HCAs moving into a role in acute care as is highlighted in the examples chosen (quotes) to represent the participants in Chapter 5. There were many examples of participants creating opportunities to learn and getting the most out of their day to day working lives through getting to know, and being known by, the ward team. A sense of positivity was apparent throughout the interviews with 'A positive outlook' being a key interpretative theme from the six month interviews.

7.4.3.2.. Newcomer adjustment

The idea of newcomer adjustment proposed by Bauer and colleagues (2007) linked this concept to newcomer proactivity and considered information seeking behaviour to be an antecedent of newcomer adjustment. Adjustment has been defined as role clarity, self-efficacy and social acceptance (Bauer et al 2007). These authors also made the link between newcomer adjustment and

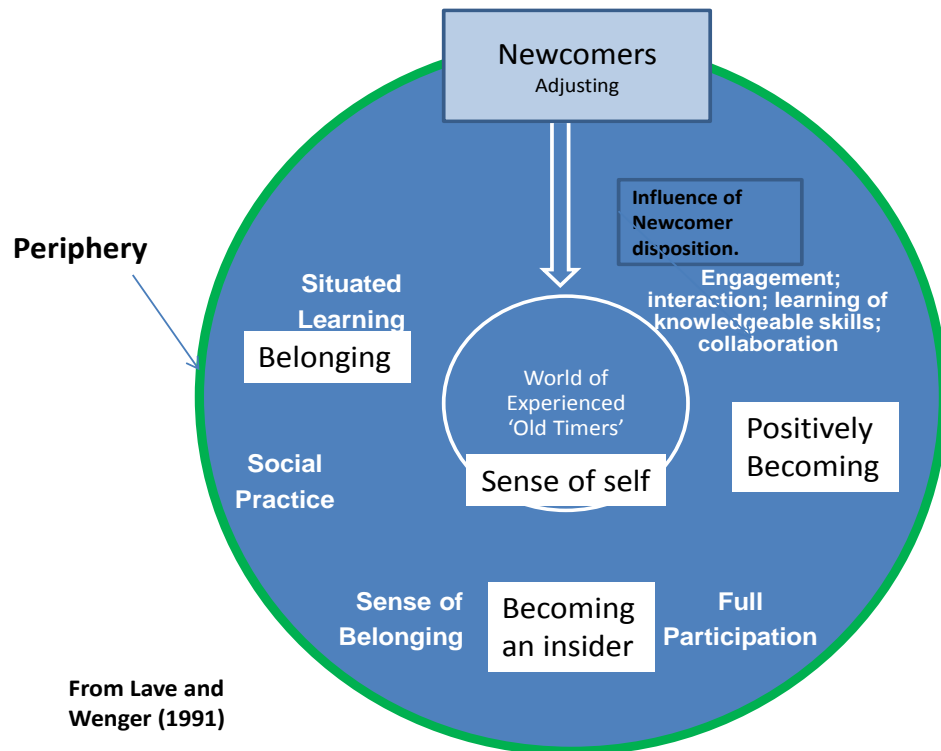
organisational socialisation, a concept that was briefly discussed in chapter 2. The participating HCAs were usually the only newcomers in their particular ward environment as they had left behind the potential social support structure of their initial induction group and most wards were only employing one new HCA to start at any given time. The study HCAs saw themselves as individuals joining a ward team, not as a cohort of new starters going through a joint learning experience. Initial references to 'we' in the 3-4 week interviews had disappeared by six months. Mignerry et al (1995) linked this sense of being one person going through a role change to newcomer proactively, whereby the employee attempts to manipulate the environment to meet personal needs. Houghton (2014) used the term newcomer adaptation as a concept to try and understand the strategies that were employed to fit in with (adapt to) the world of practice. This has a particular resonance with the study HCAs who talked a lot about wanting to fit in to their ward and were working out ways to make this happen. Houghton (2014) also made the link between newcomer adjustment and organisational socialisation and identified personal attributes and newcomer disposition as being key factors in whether the adjustment was successful or not for the newcomer. A key theme from the literature on newcomer adjustment which falls outside the voiced experiences of the study HCAs was the key significance organisational socialisation tactics. This refers to structures and processes that the organisation puts into place to facilitate adjustment, such as clear stages for training and a clear time table for role adjustment (Ashforth et al 1998). The impact of initiatives which could be seen as being designed to support HCAs new in post, such as the induction programme and the Care Certificate, were rarely mentioned by the study HCAs. The fact that they chose not to refer to them suggests that they were not seen as being significant to the lived experience over the six month period. Also, the key study theme of **a sense of self** does not fully resonate with this theory as it is a theory with a focus on the external behaviours of individuals.

7.4.4. A Sense of Self

This study theme is reflected in the work of Lave and Wenger (1991) that has already proved to resonate with the findings of this study. In their work on legitimate peripheral participation, these authors identified with a concept of 'embodied person' and a link to self-identity that sits well with the theme of **sense of self** as experienced by the study HCAs. Lave and Wenger had a view that individuals come to a new place or role with beliefs, understandings and values already formed. They considered that the whole person learns to belong to their new setting through adapting and modifying their whole person (and their sense of self) in the process. For the study HCAs it could be said that they came to their new role in acute care with an already formed value of caring and a conception of themselves as carers. They then learnt to belong to their new setting through adjusting, adapting and modifying their whole person- a change which had not gone unnoticed by themselves or others.

The diagram below (Figure 7.2) maps the concepts of legitimate participation and newcomer adjustment to the themes of the study.

Figure 7.2 The lived experience in relation to Legitimate Peripheral Participation within a Community of Practice



7.4.5. Becoming a Baker

This subheading relates to a study that used the concepts of Lave and Wenger (1991) in a longitudinal exploration of the four year journey of apprentice bakers in New Zealand (Chan et al 2013). The apprentice bakers came from a range of backgrounds and experiences and as such had similarities with the study HCAs. This example was chosen as it brings the theoretical concepts discussed in the previous sections, together with the key themes identified from the voices of the HCAs in the study (highlighted in bold), to a specific example which has a resonance the experiences of the HCAs new to acute care. The overlap to the key themes from the lived experience of HCAs new to a role in acute care is highlighted in bold in the text below. In the study of bakers, a contemporary apprenticeship model was developed which identified the phases of *belonging* to a workplace, *becoming* a baker, and eventually *being* a baker. This was seen as a process of skill acquisition, knowledge consolidation, disposition transformation and occupational identity formation that involved the crossing of boundaries (**becoming an insider**) as the bakers became more experienced. In the study of bakers, it is the first stage, the belonging to the workplace that particularly fits with the timescale (six months) of the study of HCAs. This initial stage for the bakers involved movement from detached observer and proximal participant, to acceptance of a **sense of self** as novice, learner, apprentice, and imminent baker. At this stage, Chan et al (2013) found that that personal agency (**positively becoming**) on the part of the new apprentices was an important contribution to their sense of **belonging**. The authors gave examples of the apprentices making changes in their personal lives, e.g. cooking dinner earlier and sorting child care that were thought to assist in establishing connection and engagement with bakery work and the role. At this stage the bakers moved from *hopeful reactors*, being unsure as to what the role was and what their place was in it, to *passion honers* where they became committed to the role of baker. The concept of *proximal participation* (from the work of Lave and Wenger 1991) was used in the study of bakers to explain how engagement in an associated job, lead to on-going connection with a workplace and progression into a craft or trade occupation. The authors concluded that, for

'semi-reluctant' entrants to the bakery occupation, formation of a sense of 'belongingness' (Levett-Jones et al) was identified through the inauguration of aspects of 'mateship' that occurred early on in the apprentice experience. The second stage of becoming a baker occurred after the apprentices felt they **belonged** to the workplace. At this point they were consolidating knowledge and absorbing inter- subjective understanding of the role. They moved from dependent learners and through a process of guided participation developed increased autonomy and the ability to multi task. They adopted localised understanding possible through embedded cognition. The authors used the findings of the study to develop a model of apprenticeship around the identified themes of belonging to a work place, becoming and being. They considered that these were useful for explaining the apprentice journey. The similarities between the early experiences of the bakers and the HCAs who took part in the study, particularly the concept of belonging to the workplace as the first stage in the experience, further reinforced the emerging idea that the HCAs new to acute care were having experiences that fitted with the tenets of apprenticeship, particularly as viewed through the concept of legitimate peripheral participation. The key concept that the apprentice bakers failed to have in common with the study HCAs was the fact that were identified as being semi reluctant entrants to their new job role, with no real sense of purpose. They gained a sense of direction as they progressed in their role. This is in contradiction to the HCAs starting a new role in acute care, as even though they were not always sure what the role entailed, they had entered it decisively and for clear reasons.

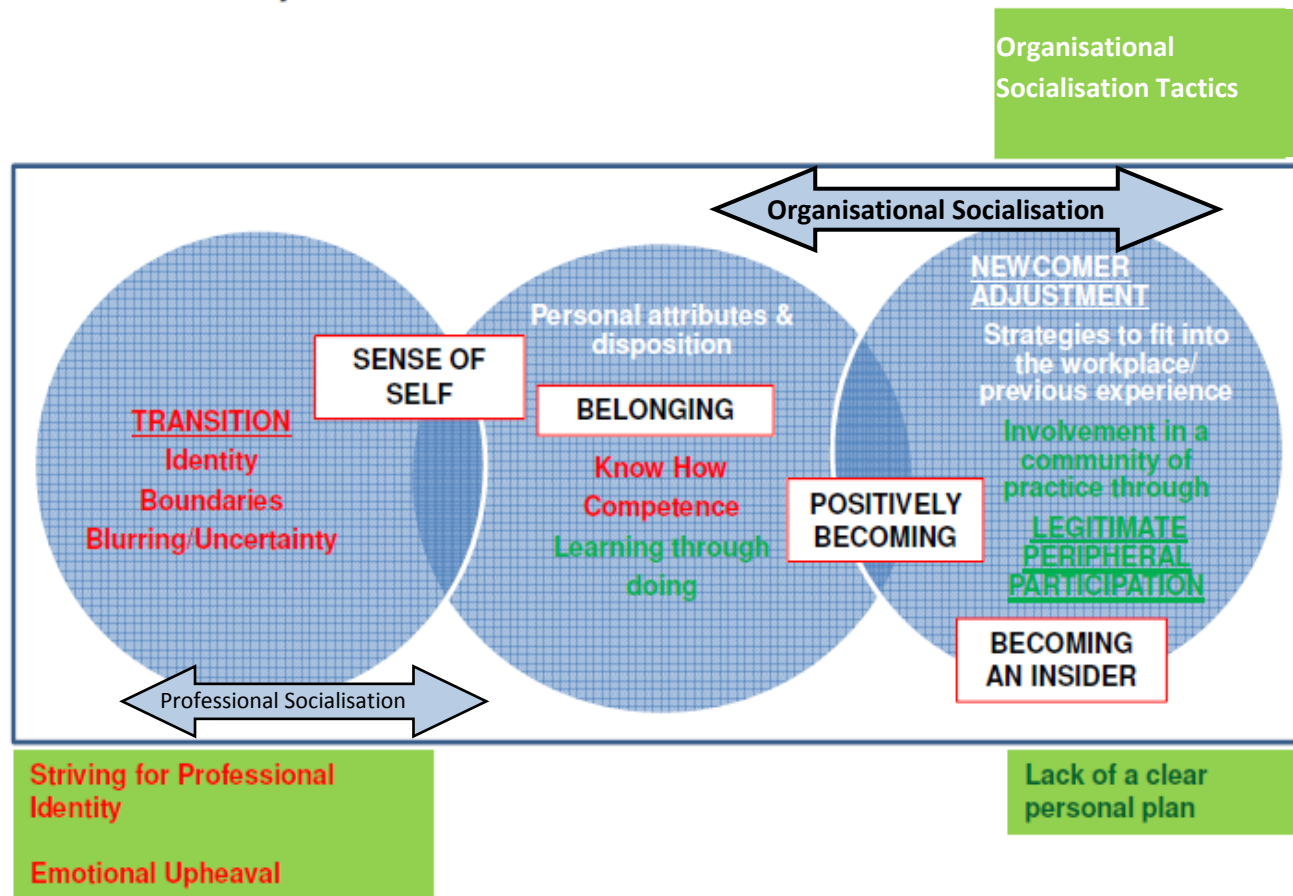
7.5. Bringing it all together - an emerging conceptual framework

In the context of this study, the aim was to produce a view, a conceptual framework, for the lived experiences of the participating HCAs in a way that had resonance, meaning and usefulness to others. A conceptual framework has been described as the current version of the researcher's map of the territory being investigated (Miles and Hubberman 1994). It is developed to account for, or describe, abstract phenomena that could occur under similar conditions (Rudestam and Newton 2014); whilst aiming to avoid distorted, one sided reductionist explanations of complex phenomena (Elaine Botha 1989). A

conceptual framework can be seen as the beginnings of theoretical thinking that acts as precursor to, and evolves into, the development of theory. The framework aims to facilitate understanding of the complex phenomena being explored. It is not intended as a substitute for reading the study in its entirety or for allowing the reader to bring their own interpretation to the findings.

The diagram in Fig 7.3 maps the voices of the participants, as interpreted through the study themes, with the key concepts from the theories of transition in nursing; newcomer adjustment and legitimate peripheral participation (as illustrated by the experiences of the apprentice bakers); and the voices of the study participants (as illustrated by the key themes from the study) into a diagrammatical conceptual framework. This hopefully helps the reader to contextualise the experience of the study HCAs during their first six months in a new role in acute hospital care. This diagram highlights the fact that whilst all three theories have some correlation with the study participant's experiences, there is not one which is fully representative. The emerging idea that the experiences of the participating HCAs straddle the concepts of a) transition and belonging to the role of an HCA with b) the concept of newcomer adjustment and belonging to the workplace (in this case the ward) as conceptualised through the key concepts of the theory of legitimate peripheral participation began to take hold.

Figure 7.3 Model of the lived experience in relation to the key theoretical concepts – Transition, Legitimate Peripheral Participation and Newcomer Adjustment



NB: The boxes outside the main diagram illustrate theoretical themes that fall outside the lived experience for the study HCAs

7.6. Conclusion

This chapter has used the four key themes of the study developed from the voices of the study participants - of becoming an insider; belonging; positively becoming and a sense of self- to explore the literature on the experiences of HCAs new to a role with acute hospital care. It became apparent that the nursing literature on transition, which has links to the theory of professional socialisation, was not always the closest fit to the experiences of the HCAs in the study. Their lived experiences involved becoming individual HCAs within their unique ward team and gaining a sense of belonging in their specific role within this team, rather than belonging to a defined peer group or a defined role. It was whilst reading the literature around newcomer adjustment, becoming an insider and proactive newcomers, which is framed within the concept of organisational socialisation and often linked to studies of apprenticeship that the concept of legitimate peripheral participation surfaced. This concept was considered to have a particular resonance with the voices of the HCAs who participated in the study. There was a growing sense that belonging to their ward was significant to the lived experiences of the study HCAs. A diagrammatical representation of an emerging conceptual framework for the experiences of the study HCAs in relation to existing theories of Transition, Newcomer Adjustment and Legitimate Peripheral Participation has been presented. The next chapter draws together the study findings with a particular focus on the factors that have inhibited or facilitated the experience for the study HCAs. This further informs recommendations for practice, education, policy and future research.

Chapter 8: Study Conclusion

8.1. Introduction

This final chapter highlights how a new framework of transition for HCAs in Acute Care provides a unique contribution to knowledge and offers a foundation for healthcare professionals to consider its implications within their work. The chapter puts the research into perspective and is careful to make the reader aware of the limitations of the study and to not make inappropriate claims about the generalisability of the study findings. However, it does offer the hope that understanding more about the lived experiences of HCAs in relation to their experiences of belonging to their role and belonging to the ward through becoming insiders, adapting to change and potential impact on their sense of self; will have benefits beyond the experiences of the study participants. The chapter presents the recommendations of the study including the implications for clinical practice and education. The potential relevance of the study findings for health care policy is outlined and suggestions made for further research.

8.2 The scope of the conclusion to the study.

The underpinning philosophical foundations of this study, that of hermeneutic phenomenology (as outlined in Chapters 3 and 4), which was selected as the best approach to address the study research question, led to a methodology designed to produce findings that are concerned with the lived experience of the everyday world. The aim was to reveal meaning rather than to focus on arguing a point or developing abstract theory (van Manen 1997). The findings in hermeneutic phenomenology are said to be an invitation to others to 'come and look along with us' rather than extracting generalisable 'this is true for everyone' series of statements (Smythe et al 2008). This study has looked at the experience of twelve HCAs starting a new role within an acute care hospital environment and has explored how they have lived this experience across two moments in time. The final product of phenomenological research is an interrelationship between the voices of the participants and the interpretation of the researcher (Cohen et al 2000). It is said to be a journey of thinking involving

a cycle of reading and writing a dialogue that spirals onwards (Smythe et al 2008). Chapters 6 and 7 have illustrated this whereby the study themes developed from the voices of the participants were gone over back and forth in relation to established theoretical concepts to find where they had resonance. The final product is not a 'truth for all time' (Smythe et al 2008) but rather a starting point for thinking and understanding. The aim of the study was to explore the lived experiences of a sample of HCAs new to a role in the acute NHS Trust known to the researcher. This is a useful way for beginning to understand experiences about which little is known and is an appropriate way to inform knowledge about the experiences of HCAs new to acute hospital care, of which, as outlined in Chapter 2, there is currently limited knowledge. The aim of the study was to tell the complicated story of the data obtained from the voices of the study participants in a way that convinces the reader of the merit of the findings and with enough clarity to deduce the transferability of the findings to similar and wider contexts (Braun and Clark 2006).

8.2.1. Limitations of the study

This study has illustrated throughout the decisions that were made in relation to the methodology and subsequent method. Hopefully the reader is left with an understanding of the rationale behind each part of the study and is assured that it was conducted in the best way possible way to answer the research question. Any research study will have its limitations due to the choice of method and the practical considerations around the circumstances of the study. These have been highlighted in the body of the text where they have most relevance. The potential imitations of the phenomenological research method are discussed in Chapter 3 including the limitations of purpose and method in section 3.3.5.1 and the limitations of usefulness to practice in section 3.3.5.2. The practical considerations potentially impacting on the study are outlined in Chapter 4 in section 4.6. Research needs to develop and evolve in order to grow knowledge, with initial studies such as this one providing direction and impetus for subsequent research. Suggestions for further research are included in this chapter in section 8.7.

8.3. A summary of the lived experience of the study HCAs

The lived experiences of the twelve HCAs participating in the study has been explored through semi structured interviews at two moments in time and then reviewed to give an overview of the experience over six months. The richness of the experience is best seen through the voices of the participants and it is important that these original voices do not get lost through the interpretation. In phenomenological research it is considered important to balance the research context by considering both the parts and the whole (van Manen 2006). For this reason it is useful at this stage to go back to the account of the interpretative themes from the original interviews. This was provided in detail in Chapter 5. and is now summarised. It is these original voices that were most informative for the secondary aim of the study which was to identify factors that had an influence (positive or negative) on the lived experience of the study HCAs. This is discussed in section 8.4.1. of this chapter. In keeping with the approach of van Manen which has informed much of the execution of the study and was outlined in section 4.2.2., it can be seen that the lived experiences of the study HCAs fall largely into two of van Manen's lifeworld categories. The study findings have a resonance with 'lived space' (spatiality) which is seen as a place which is 'felt' and is where we find ourselves in relation to how this makes us feel, and 'lived human relations' (relationality) which is seen as the lived human experience we maintain with others in the interpersonal space that we share.

At 3-4 weeks when the participants had completed the induction programme and were just coming out of a supernumerary period on the ward, there was a strong sense that they felt they were at the start of a personal journey that was planned with clear times scales and they were eager to move forward. Most had chosen to work 'for the NHS' for clear reasons. At this time the participants described a dichotomy between feeling powerless within the, often vividly described, confusing reality of the role, set against a clear sense that this should be a moment to take control over the direction their lives were taking. A month into the role there was a growing realisation of the personal commitment

that the role would entail both in practical terms of juggling work life commitments and adjusting to the 12 hour shift patterns; but also of the emotional and physical impact of working with the particular case load of patients with complex medical problems. Caring for the acutely unwell, particularly the dying was a new experience and a challenge for many. The HCAs were gaining valued emotional and practical support from friends and family and were beginning to see how others in the team had the potential to influence their experience. At this early stage the HCAs were reflecting on their new role and their perceived ability to perform successfully in it. They were aware of the clinical skills they needed to function in the role and were keen to learn these. There was an appreciation that what they were doing was important and a sense that they were now facing the reality of a role that they hadn't properly thought through. At this stage they felt outsiders to a role that they felt was not legitimately theirs.

At six months there was a strong sense of positivity and a feeling that they were on track to make a success of the role. At this point, the HCAs were focusing on making the current experience a good one for themselves rather than considering moving on to new things. Being the one new HCA on the ward meant that the participants were working out individual strategies to adjust to their role. At this stage the relationships built on the induction programme were no longer relevant and it was the relationships with the staff in their ward team that were significant- particularly the influence of the Buddy and the Ward Sister. The participants spent time observing the workings of their ward and how the different individuals worked together. They were now starting to use this knowledge to their advantage in order to take some control over their day to day working lives and the momentum and direction of travel in their development. There was a sense that they learnt the most by 'doing' in their ward environment with the induction programme and care certificate rarely being mentioned as having significance to their experience.. There was now a focus on becoming part of their ward rather than 'working for the NHS', which was a phrase often used at the first interview. Many described successfully rising to challenges of caring for particularly acutely ill patients and through this

seeing that they were now actively performing in their role. This was helped by a sense that they were being allowed into the ward team; they described feelings of being valued and a sense of belonging. Alongside the outward looking descriptions of the experience (what they were doing, how they were doing it), at six months the participants chose to reflect on how they felt as individuals, their sense of self. Many participants perceived that they had changed as people in the six months particularly through becoming more confident in approaching others. This was something that had been noticed by those around them. Also of significance was the continued perception of themselves as carers. This was something they felt they brought with them to the role at the first interview and to some extent this sustained them through the challenges of the caring for case load of patients they were now working with in their acute wards.

Chapters 6 and 7 have taken the voices of the participants at two ends of a six month experience and explored how they shed light on to the lived experience as a whole. This is illustrated in Figure 6.1. Over this time frame there was a sense of finding their way into their role through knowing what to do and appreciating the significance of the role. There was a feeling of belonging to their ward, through positive team relationships, support from key team members and being relied on by others; so that even though they were in some ways on their own as the new HCA on the ward, they did not feel alone. Positive adjustment to the role through proactively taking a degree of control over their experience was seen in the participants coping with the unpredictability of the day to day demands of working on their wards and successfully meeting the challenges of caring for acutely unwell patients. They were learning through doing in the context of a supportive environment. Throughout the six month time frame the HCAs perceived that they were staying true to themselves and their original perception of themselves as a carer although they acknowledged that they had grown significantly as individuals during this period.

8.4. The conceptual framework of the lived experience of HCAs during their first six months in a role within an Acute Hospital setting.

The key interpretative themes identified through a review of the emerging, diminishing and consistent themes in Chapter 6 (Becoming an insider, Belonging, Positively Becoming and Sense of Self) were explored in relation to the theoretical concepts of Transition in nursing, Newcomer Adjustment and Legitimate Peripheral Participation in Chapter 7. This identified that whilst all three theories had some degree of resonance with the experiences of the study HCAs there was none that fitted the experience completely (Figure 7.3). This suggests that this study is unique in both its research question and in its findings. The discussion in chapter 7 has highlighted how the experience of the participating HCAs straddles that found in the literature on Professional Socialisation, specifically Transition; and that found in literature on Organisational Socialisation, namely Newcomer Adjustment and Legitimate Peripheral Participation, which have largely been developed through the study of those in Apprenticeship roles.

The fact that the key themes from the study have an overlap with two distinct theories of socialisation within a work context sits well with emerging idea that the experiences of the study HCAs fell between those of student nurses and those of apprentices outside

a health care role. This has implications for supporting newly appointed HCAs work which will be highlighted in the section on recommendations for practice (8.5). Transition theory has a focus on belonging to a particular role, in the nursing literature this is the role of a registered nurse; whilst the theories of Newcomer Adjustment and Legitimate Peripheral Participation are concerned with belonging to a place of work. This resonates well with what was being voiced by the study participants as heard by this researcher i.e that the first six months of adjustment to a role as an HCA in an acute care hospital ward involved two key facets- that of belonging to their particular individual role and belonging to their ward.

8.4.1. A sense of belonging

Over the six months of the study period the HCAs were developing strategies to gain a sense of belonging to the role of HCA on their particular ward. They were positively working towards becoming whatever that required. It was not so much about becoming an HCA but about gaining a sense that they had filled a particular gap on that particular ward by way of belonging in the space that was there for them to fill. They had gradually gained a place inside their role. This sense of fitting into what the role requires has been termed 'job fit' and is recognised as being important in adjusting to a new role (Laschinger et al 2006). The participants were not aspiring to a particular end point to be a fully-fledged HCA, but to be able to do what well what was needed for their ward. This involved retaining certain characteristics that they brought with them; specifically their ability to care for people and the importance they placed on this caring; but also growing in confidence and an increased capability to look after the particular patients in an acute care hospital environment. Alongside this sense of belonging to their role, and possibly more significant, was the sense of belonging to their particular ward, to their work place. Feeling part of the team, being allowed into the team through being accepted for whom they were and being supported by key members of this team was the most significant thing for many of the study HCAs in the six month period. An earlier sense of being part of the NHS or belonging to the May 2015 HCA induction group were not evident at six months.

The importance of belonging is acknowledged in the literature on both Professional Socialisation and Occupation socialisation. It is recognised as a basic human need (Baumeister and Leary (1995) and has been described as a deep personal contextually-mediated experience whereby the individual feels accepted and valued within a defined group with similar values (Levetts-Jones et al 2009). This is where the study HCAs had a particular resonance with experience of the apprentice bakers in Chan's 2013 five year study that was outlined in section 7.4.5. It was a sense of belonging to the workplace that was

the first phase identified for the study bakers. This early sense of belonging was linked to an on-going connection with the workplace and an affinity with the work carried out there, particularly through the establishments of interpersonal relationships. This initial sense of belonging to the workplace has been seen to be important to retention and on-going commitment of new starters to a role (Fuller and Unwin 1999, Fuller et al 2005) and to be facilitated by an appropriate supportive learning environment in the workplace (Chan 2016). The study HCAs were learning most through working in their ward areas and the concept of the ward as a Community of Practice (see 7.4.1.3.) to develop specific knowledge and skills through situated learning whilst fostering a sense of belonging is something that warrants further attention and exploration and is discussed further in section 8.5.1.1.

8.5. Implications for Practice

This study forms part of an academic qualification that aimed to develop research skills that facilitate the practical application of theory into clinical practice. It is envisaged that the knowledge gained from this study will inform the researcher in her capacity as an education and practice development nurse working with HCAs in an acute hospital trust. It is anticipated that the findings will be used with positive effect to influence the experiences of HCAs during their transition into their role in an acute care setting. It is hoped that this study will have wider potential to inform others working with the non-registered nursing workforce in clinical practice and be used to guide clinical practice developments through evidence based education, policy and research.

The key recommendations rising through the voices of the study participants, as interpreted through the key themes of the study, focus on recognising the unique experiences of the HCAs and are outlined in section 8.5.1 below. This is informed by the secondary aim of the study which was to identify factors that impacted on the HCAs lived experience either positively or negatively. The theory of transition developed by Meleis et al. (2000) considered that there are a number of conditions that can influence change in role including personal, social and environmental factors. These conditions, recognised as facilitators

and inhibitors can enable or constrain both the process and outcome of the experience (Meleis 2010). The table in Appendix 23 illustrates how the themes from the interviews revealed factors that facilitated or inhibited the experience of the HCAs in their first six months in post. The table in Appendix 23 also includes practical suggestions as to how an awareness of these factors could be used to improve the experience of HCAs new in post. The key measures identified are highlighted in the two paragraphs below. The factors influencing the lived experiences of the study HCAs have been presented to the Trusts Education and Practice Development team and some of the suggestions in the table are theirs. Several of the recommendations have already been implemented in practice. The programme is now delivered in full before the HCAs start on their wards and the HCAs wear their uniforms whilst attending the study days.

8.5.1. Appreciating the unique experience of the HCAs

The study findings have highlighted that the participating HCAs had unique lived experiences that have a resonance with those of both student nurses and those entering work through an apprenticeship route. This suggests that treating newly appointed HCAs in the same way as student nurses is likely not to be the best approach. The current focus within hospital nurse education teams is often the on-going development of pre and post registration nurses and any shift towards developing the non-registered nursing workforce is going to be a new challenge. The current focus on the potential for this non-registered nursing workforce to contribute to the clinical wards of the future through apprenticeship style routes to assistant practitioner, nursing associate and registered nursing roles (as outlined in Chapter 2) means that there is a growing impetus to provide relevant induction support and on-going development for these staff beyond their initial induction. Not all HCAs will want to progress beyond the Band 2 roles. Whilst the twelve participants in this study had ambitions to move to a higher pay banding when interviewed at 3-4 weeks into their post; at six months, most were realising a need to consolidate their experience before thinking about moving up the nursing career ladder. Several felt that they were now happy where they were. There will always be a requirement for Band 2 HCAs and whether this is as a starting point for career progression or a long

term role, it is important both for recruitment and retention that their initial experiences are positive ones and meet specific needs. The study themes of belonging to their role and belonging to their ward lead to recommendations around fostering a sense of belonging and, as part of this, creating a ward environment that has a positive influence on the adjustment to working within it- in other words a community of practice as outlined in section 7.4.1.3.

8.5.1.1. Fostering a sense of belonging

The HCAs tended to be on their own as new starters on their wards and learnt the most by learning on the job. Their allegiance was to their ward team and not to an academic institution, student cohort or job role. As has been discussed, developing a sense of belonging to their role and in particular to their ward was significant for them throughout the six month period. The literature suggests that being recognised as an individual, and being accepted as such, is key to a sense of belonging (Hodkinson et al 2004), and the study HCAs certainly recognised this. It has been identified in the literature on the experience of student nurses in clinical placements (Brown et al 2008a), that an initial focus on self and the creation of a sense of security and belonging is a crucial part of the experience of being in the clinical environment. This paves the way for the nature of the rest of the experience (Brown et al 2008b). Developing practices as suggested in Appendix 23, whereby individuals are encouraged to tell their stories; are given early appraisals where their previous experience and life journey are acknowledged and are allocated patients to look after where they are able to use existing caring skills are ways in which this acceptance as an individual and a sense of belonging could be fostered. A recognition of the feeling of being an outsider, an imposter and definitely not belonging at the start of the new starters experience could be acknowledged through initial visits prior to commencing on the ward. Meeting with the Buddy prior to starting in order to highlight things to expect such as the types of patients, team roles, a typical shift, what things are called and discussing strategies to adjust to shift patterns are other measures that are likely to be helpful. Relationships between the individual and the team are key to the experience of developing a sense of belonging (Levitt- Jones et al 2008) and this was borne out by the experience of

the study HCAs who identified key individuals who had made a positive difference to their experience. They felt that belonging to the ward team was one of the most significant factors in their first six months on their wards. As outlined in Appendix 23 practical ways of supporting the development of positive relationships for the new HCA include: recognising the important part the ward sister has to play in welcoming a new HCA to the ward; aiming to match the Buddy to the HCA in terms of experience, personality and learning needs and involving the new HCA in the communication networks of the ward. Central to achieving sense of belonging is the relationship that the new starter has with their ward as a community of practice: a place to work, a place to learn and a place to belong. It is also worth acknowledging that the framework of the experiences of the HCAs in the study did overlap in some parts with the experiences of student nurses. Student nurses have an allegiance to university class group and there may well be some mileage in encouraging a sense of on-going belonging to the initial HCA induction cohort in terms of long term peer support.

8.5.1.1.1. Optimising the ward as a Community of Practice and facilitating situated learning

Considering the ward environment as a potential community of practice sits with the literature on the experiences of apprentices (it is a component of Lave and Wengers 1991 theory of Peripheral Participation (see section 7.4.1.3.) where it was first developed as a concept, but it also resonates with the limited literature on communities of practice within nursing (Andrew et al 2008). Building on the previous section, an effective community of practice needs collaboration, participation and most significantly belonging in order to develop effectively (Andrew et al 2000). Those that do not experience a sense of belonging in the clinical environment learn little (Brown et al 2008 a). A community of practice has the potential to transform an individual's sense of identity (sense of self) within their work place role (Sayer 2014). An effective community of practice needs to facilitate work based collaborative learning in order that individuals work to a common purpose (Andrew et al 2008). Central to this is the knowledge required to get the job done (Wenger 1998). Certainly the study

HCAAs were aware that working with patients on the wards of an acute hospital trust required more specialist knowledge about medical conditions and how these impacted on patient care than they currently possessed. One of the recommendations for the induction and on-going education of HCAAs new to a role in an acute care environment is the provision of knowledge to equip them to best care for the patients in their case load. This includes appropriate knowledge of medical conditions but also the knowledge and skills to care for patients with altered behaviours and those who are dying. Whilst some of this could be done in a classroom situation, there is also scope for ward based learning through, for example, case studies, simulation and role modelling with the support and guidance of a knowledgeable and respected colleague (Spouse 1998). To date there is limited structure and consistency for practice based learning for HCAAs. Knowledge gained through informal workplace learning is often not acknowledged or valued within organisations and is thus often rendered invisible as learning (Boud and Middleton 2003). This is despite the fact that the study HCAAs identified that they learnt the most through working in the ward environment. Learning in the workplace, often referred to as situational learning, is key to apprenticeship style on the job training and practice based learning. It is also a key component of student nurse training (Cope and Cuthbertson 2000, Field 2004). There is evidence that a ward environment that is 'enriched' in terms of creating conditions that allow the development of a positive work view, are welcoming and provide supportive mentorship, facilitating a readiness to learn in the individual (Brown et al 2008). There is evidence that HCAAs can enrich the learning of student nurses (Hasson et al 2013b) and there is scope for exploring shared learning experiences for registered and non-registered staff within the clinical environment. There is much potential to develop situated learning for HCAAs within the concept of a community of practice in order to give it structure, purpose and value.

8.6 Implications for policy

The findings of this study have a relevance to and implications for current health care policy in regard to HCAAs working in acute hospital settings.

As outlined in the NHS Five Year Forward Review (NHS 2014), patients in secondary care hospital environments are likely to have more acute needs as care is increasingly provided in community settings and in the home. This review anticipated that there will be challenges to meet the needs of those requiring hospital care as we live longer with more complex health issues. The nursing care work force, including non- registered nurses, faces the challenge of having the right skills to meet patient care needs (Willis 2015). This study of HCAs new to acute hospital care has highlighted that, whilst the concept of 'caring' appears to cross the boundary from a previous role in an out of hospital setting to one in an acute NHS hospital trust, HCAs new to an acute care environment would benefit from focused development opportunities to equip them in their role in caring for acutely unwell and potentially unstable patients with complex care needs. The resources and time needed for this need to be factored into workforce planning and recruitment strategies.

One of the key drivers for the study, as outlined in Chapter 1, was the recognition that the 'shape of caring' i.e. the composition of the team providing care around the patient, and the way that care is delivered, will need to adapt to the demographics of the health care workforce in the years ahead (Willis 2015). Economic pressures, challenges with recruitment and retention and the aging profile of the nursing workforce all indicate a future with fewer registered nurses (Griffiths et al 2016). Current plans for workforce development in England point toward a significant increase in the numbers and proportion of non-registered care workers relative to the number of registered nurses and registered nurses (NHS England 2017). Acute Trusts are redesigning the structure of care delivery teams by making use of non- registered care (NHS Employers 2018a). The opportunities for non-registered staff to progress to band 4 assistant practitioner and nursing associate roles are in the spotlight and the non-registered nursing workforce is assuming increased significance in the workforce plans of acute trusts (Willis 2015, NHS England 2017). As non-registered staff leave band 2 posts to move into new roles, NHS trusts will need to develop strategies to replace them at the bed side. This requires effective recruitment and retention policies for this group of staff. Band 2 HCAs

will need to be available in sufficient numbers and with the right knowledge and skills to fill the void left by those moving into the new roles. This study of 12 band HCAs newly appointed to a role in one acute care trust has the potential to inform recruitment and early organisational strategies for these staff working in the wider secondary care environment. For example, the study theme of positivity becoming, which was a characteristic of HCAs who felt themselves to be in a good place during the six months of the study, suggests that using the recruitment process to identify candidates with a proactive and positive outlook has the potential to select applicants likely to be best placed to have a good experience early on in their role. The study HCAs at the start of their employment in acute care were ambitious and forward thinking but were not clear about the role they were entering. This points to a need for clarification of the scope of the Band 2 role and the need for more detailed pre-employment information so that potential job applicants are able to make the right career choices. There is a case for having clearer job descriptions and information around the day to day realities of the role in order to attract informed applicants who come into post better prepared for the realities of the role. Practical ways employees could improve the experience of newly appointed HCAs have been highlighted in Appendix 23.

There is scope for the Band 2 HCA role to become the recognised foundation for non- registered nursing career progression (Twigg et al 2016, NHS England 2017). To be effective this is likely to necessitate a national overview of the role and the development of a clear policy for moving up through the pay bands and job roles. It is recognised that the development of non-registered nursing roles currently lacks cohesion and clarity (Glasper 2016) which is potentially exacerbated for those newly appointed at band 2 level who currently lack the attention and focus that is on other non-registered nursing roles. This study points to the potential benefits of clear and comprehensive development pathways for individuals early on in the band 2 HCA role. As early as the first interview the study HCAs were keen to progress and were seeking out ways to move forward in their role. The fact that they HCAs had differing aspirations and a range of time scales for moving forward (some wanting to go into nursing

relatively quickly but more wanting to consolidate their experience as an HCA before deciding what to do next) suggests that these development options need to be flexible.

This study has developed knowledge that has the potential to enhance the early experience of HCAs new to an acute care setting. It has highlighted the importance of a positive experience in the first few months which fosters adjustment to the new role and a sense of belonging to the ward environment. Local induction policies need to incorporate organisational socialisation strategies which allow time for relationships to be built and for new HCAs to become confident and competent at caring for the acutely unwell patients that they will encounter in their roles.

The current policy for a clear commitment to use apprenticeship models of learning in health care has been seen as an opportunity to strengthen the team around the patient (NHS Employers 2018b). The findings of this study of the experiences of band 2 HCAs point to a link between their experiences and existing models of apprenticeship (see section 7.4.1.1. in Chapter 7). There is potential to learn from these models and incorporate best practice into the structure and content of apprenticeships in health care.

8.7. Suggestions for further Research

It is envisaged that this initial exploration of the lived experiences of twelve newly appointed HCAs to a role within one NHS hospital trust over a six month period has the potential to act as a catalyst for further research. There is scope to ask questions about the experiences of comparable HCAs in a different way; to use the study method to replicate the research question in other groups of non- registered nurses and to also to look further into the themes generated from the study. Specific suggestions are:

- To explore the lived experiences of HCAs new to a role within acute hospital care over a longer time frame. Six months was a necessary time constraint of this study. Other studies of experiencing a new role have been longer and it would be useful to see if the study themes evolve over

time and whether the influencing factors change. It would be particularly interesting to explore whether the HCAs focus on themselves as predominantly person centred carers shifted after prolonged exposure to an acute hospital care environment. .

- To use a similar methodology to explore the lived experiences of other non- registered nursing staff- there is limited knowledge on the experiences of Assistant Practitioners and the new role of Nursing Associate. It would be interesting to explore whether having a course structure and a role end point changed the experience significantly from that of the Band 2 HCAs in this study
- To use a different methodological approach to look at the experience of HCAs in a different way. The last part of this research study was carried out with supervisory support from Professor Jayne Brown who has been involved in research with student nurses using a constructivist inquiry approach. This involved a larger sample, a longer time frame and multiple methods of data collection including focus groups, postal surveys, and case studies (Brown 2005). It would be interesting to use a similar methodology see if HCAs new in post had a focus of attention and effort that varied over time in a comparable way to that of student nurses.
- To explore further the concept of the ward environment as a community of practice and how this influences the experiences of those within it and how it impacts on situated learning. This could involve including other members of the ward team to identify what makes for an enriched environment to support non- registered nursing staff.
- To attempt to understand in more detail the key concepts highlighted in this study in the context of the experiences of those providing care in the ward environment i.e. to undertake research with a particular focus on a Sense of Belonging, Becoming an Insider; Positively Becoming and a Sense of Self.

8.8. Conclusion

This study has used a phenomenological hermeneutic interpretative approach to explore the lived experiences of HCAs new to a role within acute hospital care. This method produced rich accounts from semi structured interviews conducted at 3-4 weeks and six months which were explored for themes initially from the sets of interviews separately and then across the two interviews. Key themes were identified as Belonging, Becoming an Insider; Positively Becoming and a Sense of Self. In line with the research methodology these were explored back and forth in the nursing literature and then the literature relating to apprenticeships and newcomer adjustment to new work roles. It was acknowledged that existing models around the experience of role change within a work environment do not completely represent the lived experiences of the HCAs participating in the study although aspects of the theory of Transition in nursing, Newcomer adjustment and Legitimate Peripheral Participation had some resonance with the experience of the study HCAs. Therefore the framework developed from the study is a new conceptual framework and a unique contribution to the knowledge of the experiences of HCAs commencing a role in hospital acute care. The findings suggest that the experience of HCAs new to acute clinical care environments has many similarities with those of workers from outside the world of nursing and much in common with those in worked based apprentices. This has implications for this group of staff (HCAs), who are entering a world where nurses are the gatekeepers, nurses are their ultimate managers and the ward environment is likely to have a professional nursing focus. Suggestions have been made for clinical practice, education, policy and further research which have the potential to develop knowledge and enhance the experience of HCAs. There needs to be a focus on fostering a sense of belonging and developing situational learning through the principles of a community of practice

The findings presented in this thesis have already been discussed with colleagues and some initial changes in practice made. They will be reported in an executive summary which will be sent to all the participants along with a

letter thanking them for taking part in the study and permitting the use of their descriptions of lived experiences of their first six months in the HCA role. The findings will be presented locally at the NHS Trust where the study was conducted and may be presented at nursing conferences and published in peer reviewed nursing journals.

Epilogue

This research journey (as outlined in figure 8.1), has taken me into the lives of twelve newly appointed HCAs and has allowed me to see their lived experiences over a six month time frame. I feel that the method chosen, that which used the approach of Hermeneutic Phenomenology, was successful in enabling me to gain a true insight into the world of the HCAs who took part in the study. It was empowering at the start of the study to go into the interviews without the knowledge of what other researchers had found, but this did mean that there was much reading and to be done after the analysis stage. If I had been familiar with the literature on the experience of newcomers to the workplace before I started the study then the study may have well have taken a different route. I realise that in line with the phenomenological method chosen, the final findings are a product of the voices of the study participants and my interpretation of what I heard and I take full responsibility for this.

Looking back to the prologue written in 2015, I can see that at that point I was identifying with my own experiences as a care assistant and remembering the feeling of uncertainty and being out of my depth when I first started in roles within a psychiatric hospital and a residential care home. I was also acknowledging the positive impact of having people around me who took an interest in me and supported me. At that point I was comparing and contrasting my experiences as a non-registered carer with those I had when I was a student nurse, and again identifying that it was the ward environment that most influenced my experience. So some of the findings of this research study, particularly the importance of belonging and the influence of the ward team do not come as a surprise; but it is important to have identified them as this work has not been done previously and the findings highlight key strategies that have the potential to improve the experience of HCAs starting in a new role. It is important to know that HCAs have different experiences to the student nurses who we are used to focusing our attention on as learners in the clinical environment. What was unexpected in the findings was the individual HCAs sense of positivity and determination to enhance their own experiences. This energy and sense of purpose needs to be nurtured. At the end of this research journey I am left with an increased feeling that our HCAs are group that warrant our attention and investment.

R.A.W. November 2017.

Figure 8.1 The journey of understanding the lived experience of the study HCAs



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Appendix 1: Overview of studies of nursing transition influenced by van Manen

Author(s)	Date of publication	Country of study	Focus of Study	Sample	Philosophical framework/ Methodology	Method as described in the text	Analytical Approach	Key Findings
Alboliteeh M. Doctoral dissertation	2015	Saudi Arabia	Demographic information and survey of motivational factors. Lived experience of graduate Saudi Nurses	12 nurses for the qualitative study who had less than 5 years' experience	Mixed Methods Van Manens Phenomenological approach to Hermeneutic phenomenology Justifies the use of mixed methods as strengthening the results and ensuring rigour	- Self administered survey followed by -In depth interviews Used the qualitative phase to explore issues raised in the quantitative phase.	Interpretative analysis - read each transcript to identify initial themes -repeated this reading many times -immersed in the data to identify themes -Emerging themes and sub themes highlighted and then grouped to form major themes -discussed with the team to ensure validity	Five Key themes: nurses felt unprepared felt marginalised by expatriate nurses Saudi nurses suffered from poor social status Felt positive about their role Showed awareness of social changes in nursing
Davis-Kennedy K. Doctoral dissertation	2014	USA	Transitioning from a nurse practitioner student to an employed nurse practitioner	5 graduate students in their first semester and 5 novice nurse practitioners	Van Manens hermeneutic phenomenology	Purposeful non-random criteria based sample.	Read each transcript to identify themes --Immersed in the data to identify themes -Emerging themes and sub themes highlighted and then grouped to form key themes -	Four key themes - Starting a new journey - The adventure - Gains and sacrifices - Reflection and future growth

Author(s)	Date of publication	Country of study	Focus of Study	Sample	Philosophical framework/ Methodology	Method as described in the text	Analytical Approach	Key Findings
Gohery P. and Meaney T. <i>Intensive and Critical Care Nursing</i>	2013	Ireland	Nurses role transition from the clinical ward environment to the critical care environment	9 critical care nurses	Qualitative Heideggerian phenomenology	In depth semi structured interviews	van Manen approach to data analysis. -Transcripts read and re read - used field notes and reflections -Transcripts written and re written in the researchers own words -words and phrases that explained the experience were highlighted -these were then isolated to form themes	4 key themes: - The highs and lows - You need support - Theory practice gap - Struggling with fear.
Kavalam M.J. Doctoral dissertation	2011	USA	Lived experience of bedside nurses who transition into roles in the pharmaceutical industry.	10 non clinical workers in the pharmaceutical industry who had previously worked as bedside staff nurses	Taking a phenomenological approach	In depth tape recorded interviews	van Manen approach to data analysis - Reflecting on essential themes - Line by line analysis - Use of NVivo software	3 key themes : - Taking stock - Action - Adaptation
Ogle K. Doctoral dissertation	2007	USA	Exploring the lived journey of nurses becoming nurse practitioners	7 former masters students nurses in the process of becoming nurse practitioners	Qualitative phenomenology Heidegger Gadamer Casey Used van Manens 6 research activities as the basis of the research method.	Initial telephone conversations. Two in depth conversations using an hermeneutic interview style. Participants were asked to write about their experiences.	Typing the transcriptions, writing and re writing- letting what shows itself to be seen in the manner of Heidegger. ' Use of the Wizard of Oz as an analogy- 'following the yellow brick road'. Use of poetry and personal story telling and reflection. .	Stories are the bricks that make up the road and lead to a new way of being. Webs of support from other students are important The nurse part of nurse practitioner is important Greatest source of strength is themselves

Appendix 2: Sponsor Approval

From: Meldrum Eleanor - Assistant Chief Nurse
Sent: 13 April 2015 09:33
To: Webster Rose - Education & Practice Development Lead
Cc: Khan Zaynab - Research Support Officer
Subject: RE: Authorisation request for Study

Hi Rose

I am more than happy to give my support for this study to go ahead. I am hoping it will form part of the ongoing work around the development of our Care Assistants.

Regards
Eleanor

From: Webster Rose - Education & Practice Development Lead
Sent: 10 April 2015 10:53
To: Meldrum Eleanor - Assistant Chief Nurse
Cc: Khan Zaynab - Research Support Officer
Subject: Authorisation request for Study

Dear Eleanor

I have recently submitted the IRAS application for the research that I intend to undertake as part of my DHSci to the Research Office here at UHL. The reviewer has requested that I get e-mail confirmation that you are supportive of me undertaking this study.


The research involves qualitative tape recorded interviews with HCAs who are new to the Trust and who are about to commence their induction period. Participants will be interviewed at the start of their employment and also when they have been in post for 6 months. Informed written consent will be taken prior to participation in the study.

I enclose the protocol for the study and would be grateful if you could acknowledge your support of this study by return if you are happy for it to go ahead.

Regards
Rose

Rose Webster
Lead for Education & Practice Development- Renal, Respiratory & Cardiac and Emergency & Specialist Medicine CMGs
c/o Education Office
(opposite ward 34)
Glenfield Hospital
Groby Road , Leicester LE3 9QP
Tel: 0116 258 3060
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Appendix 3: UHL Research and Development Office Approval

University Hospitals of Leicester 
NHS Trust

DIRECTORATE OF RESEARCH & DEVELOPMENT

Research & Development Office
Leicester General Hospital
Gwendolen Road
Leicester
LE5 4PW

Director: Professor Nigel Brunsdill

Assistant Director: Dr David Hetmanski

Head of Research Operations: Carolyn Maloney

Direct Dial: (0116) 258 8351

Fax No: (0116) 258 4226

18/05/2015

Ms Rose Webster
University Hospitals of Leicester
Lead for Education and Practice Development
Glenfield Hospital
Leicester
LE5 9QF

Dear Ms Rose Webster

Ref: UHL 11414

Title: An exploratory study to examine the lived experience of newly appointed Health Care Assistants (HCAs) during their transition to a role within an acute hospital setting

Project Status: Project Approved

End Date: 30/10/2015

Date of Valid Application: 13/04/2015

Days remaining to recruit first patient: 35 Days remaining

I am pleased to confirm that with effect from the date of this letter, the above study has Trust Research & Development permission to commence at University Hospitals of Leicester NHS Trust. The research must be conducted in line with the Protocol and fulfil any contractual obligations agreed between UHL & the Sponsor. If you identify any issues during the course of your research that are likely to affect these obligations you must contact the R&D Office.

In order for the UHL Trust to comply with targets set by the Department of Health through the 'Plan for Growth', there is an expectation that the first patient will be recruited within 70 days of receipt of a Valid Application. The date that a Valid application was received is detailed above, along with the days remaining to recruit your first patient. **It is essential that you notify the UHL Data Management Team as soon as you have recruited your first patient to the study either by email to RDData@uhl-tr.nhs.uk or by phone 0116 258 4573.**

If we have not heard from you within the specified time period we will contact you not only to collect the data, but also to record any issues that may have arisen to prevent you from achieving this target. It is essential that you get in touch with us if there is likely to be a problem in achieving this target so that we can discuss potential solutions. The Trust is contractually obliged to meet the 70 day target and if an adequate reason acceptable to the NHF has not been submitted to explain the issues preventing the recruitment of your first participant, the Trust will be financially penalised.

In addition, we are required to publish the Title, REC Reference number, local target recruitment and actual recruitment as well as 70 days data for this study on a quarterly basis on the UHL public accessed website.

All documents received by this office have been reviewed and form part of the approval. The documents received and approved are as follows:

Description	Version
Consent Form-INITIAL 4/6 months	Version 1 Dated: January 2015
Letter of introduction Initial and reply slip	Dated: January 2015
Participant Information Sheet HCA transition	V1 Dated: 12 January 2015
Protocol	V1 Dated: January 2015
QUESTIONNAIRE Demographic	V1 Dated: January 2015
Semi Structured Interview Guide. Initial Interview	V1 Dated: January 2015
Staff Approved to work on this study as Per approved SSI Form are as follows:	Signed Dated: 10 April 2015
Ms Rosemary Webster Signed CV, GCP and consent Assessment to take consent all received	

Please be aware that any changes to these documents after approval may constitute an amendment. The process of approval for amendments should be followed. Failure to do so may invalidate the approval of the study at this trust.

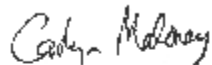
Undertaking research in the NHS comes with a range of regulatory responsibilities. Please ensure that you and your research team are familiar with, and understand the roles and responsibilities both collectively and individually.

Documents listing the roles and responsibilities for all individuals involved in research can be found on the R&D pages of the Public Website. It is important that you familiarise yourself with the Standard Operating Procedures, Policies and all other relevant documents which can be located by visiting www.leicestershospitals.nhs.uk/aboutus/education-and-research

The R&D Office is keen to support and facilitate research where ever possible. If you have any questions regarding this or other research you wish to undertake in the Trust, please contact this office. Our contact details are provided on the attached sheet.

We wish you every success with your research.

Yours sincerely



Carolyn Maloney
Head of Research Operations

Encs: R&D Office Contact Information

Appendix 4: DMU Ethical Approval



HLS FREC Ref: 1575

16th June 2015

Rosemary Webster
DHSCI Candidate

Dear Rosemary,

Re: Ethics application – An exploratory study to examine the lived experience of newly appointed Health Care Assistants (HCAS) during their transition to a role with an Acute Hospital setting (ref: 1575)

I am writing regarding your application for ethical approval for a research project titled to the above project. This project has been reviewed in accordance with the Operational Procedures for De Montfort University Faculty of Health and Life Sciences Research Ethics Committee. These procedures are available from the Faculty Research and Commercial Office upon your request.

I am pleased to inform you that ethical approval has been granted by Chair's Action for your application. This will be reported at the next Faculty Research Committee, which is being held on 18th June 2015.

Should there be any amendments to the research methods or persons involved with this project you must notify the Chair of the Faculty Research Ethics Committee immediately in writing. Serious or adverse events related to the conduct of the study need to be reported immediately to your Supervisor and the Chair of this Committee.

The Faculty Research Ethics Committee should be notified by e-mail to hlsfro@dmu.ac.uk when your research project has been completed.

Yours sincerely,

A handwritten signature in black ink, appearing to read "M. Grootveld".


Professor Martin Grootveld
Chair
Faculty Research Ethics Committee
Faculty of Health & Life Sciences
De Montfort University

Email: hlsfro@dmu.ac.uk

Web: <http://www.dmu.ac.uk/research/ethics-and-governance/faculty-specific-procedures/health-and-life-sciences-ethics-procedures.aspx>

Faculty of Health and Life Sciences, Edith Murphy House, The Gateway, Leicester LE1 9BH.
T: (0116) 255 1551 F: (0116) 257 7135

Appendix 5: Letter of Introduction

University Hospitals of Leicester 
NHS Trust

Glenfield
Hospital

Groby

Date: May 2015

I am writing to give you details of a study that is being carried out at the University Hospitals of Leicester NHS Trust (UHL) that you might be interested in taking part in.

This study is called: **An exploratory study to examine the lived experience of newly appointed Health Care Assistants (HCAs) during their first six months in a role within an Acute Hospital setting**

You have been given this letter because you have recently been appointed into a role as a Health Care Assistant (HCA) at UHL and are NEW to working in an acute hospital.

The study involves

- A questionnaire for you to complete and fill in and return – this is a short questionnaire that asks for demographic information and details of any previous care work.
- There may also be an opportunity for you to take part in two audio recorded interviews as part of this study. One in the next few weeks and one in six months time.

If you are interested you will be given more information about what is involved before you take part. If you are interested in finding out more about this study please return the reply slip below in the envelope provided.

YOU ARE UNDER NO OBLIGATION TO TAKE PART IN THIS STUDY

Yours sincerely

Rose Webster, Education & Practice Development Nurse

Appendix 6: Participant Information Sheet



University Hospitals of Leicester **NHS**
NHS Trust

Glenfield Hospital
Groby Road
Leicester
LE3 9QP

An exploratory study to examine the lived experience of newly appointed Health Care Assistants (HCAs) during their first six months in a role within an Acute Hospital setting

You are being invited to take part in a research study. Before you decide it is important for you to understand why the research is being done, and what it will involve. Please take time to read the following information carefully. Please feel free to ask the researcher if there is anything that is not clear or if you would like more information.

What is the study about?

I wish to find out about the experiences of individuals who are just starting in a role as a Health Care Assistant in an Acute Care Trust. I would like to use interviews undertaken during the first few weeks in post and again after six months to explore what it has been like to be an HCA during this time.

By taking part we hope to gather information that will inform and improve the experience of future newly appointed Health Care Assistants.

Why have I been chosen?

This is a study taking place at The University Hospitals of Leicester NHS Trust which is an Acute Care Trust. You are eligible to take part because you have recently been appointed to a position as a Health Care Assistant.

Who is involved in the study?

The study is being carried out by a nurse researcher at the University Hospitals of Leicester NHS Trust and is being undertaken as part of a programme of study at De Montfort University.

Do I have to take part?

No, the study is entirely voluntary. Whether you choose to take part or not, this will not affect your employment or your induction period in any way. If you decide to take part, you will be given this information sheet to keep. You are free to withdraw from the study at any time. You do not need to give a reason if you wish to withdraw.

What is involved?

This study involves gathering information from both questionnaires and interviews.

We want to get information from new HCAs at the beginning of their employment and also after 6 months in post.

Questionnaire:

The questionnaire that we are using is included in the pack that you will have received with this information sheet. If you wish to take part in this part of the study you can complete the questionnaire and return it in the envelope provided or you can bring it with you to the next induction programme day. The questionnaire should take less than 3 minutes to complete and asks you questions about yourself (demographic information).

Interviews:

The interviews are aimed at exploring experiences of recently appointed HCAs. I would like to conduct two interviews. The first interview will take place in the first few weeks in post and a second at 6 months in post. I think that the interviews will both last no more than 90 minutes and would take place at the Hospital where you work at a time and location convenient to you.

If you are interested in taking part in the interview part of the study would you please indicate this on the back page of the questionnaire. There will also be an opportunity to volunteer for the interviews at any point in your first two weeks of employment – please contact me on the number below or e-mail me through the UHL e-mailing system if you decide that you would like to be considered for this part of the study.

We are looking for a set number of HCAs to be interviewed for this study and as we are sending out more information letters than this- it is possible that you will not be selected for interview. We will make sure that you know whether or not you have been selected for interview within your first two weeks of employment.

If you are selected to be interviewed we will, with your written permission, audio record the interview. We will ensure you cannot be identified on the interview transcripts or any study reports.

What are the possible benefits of taking part?

It is not anticipated that there will be any direct benefit from taking part in this study although some people enjoy filling in questionnaires and taking part in interviews. We hope to use the information gained from this study to help in developing and supporting newly appointed HCAs in the future.

What happens to the information?

All the information collected will be confidential. We will need to keep contact information in order to follow you up at 6 months but after the end of the study period this information will be destroyed. No one will be able to identify you from the study. The reports of the research will be anonymised and kept confidential to the research team. All the information that is collected from the questionnaires will be put into a computer, which is password protected, to be analysed. At the end of the project all the completed questionnaires will be shredded.

Information from the interviews

The tapes from interviews will be transcribed (listened to and written down in full). The notes taken by the researcher, the tapes and the transcripts will be kept safely in locked offices at the Hospital and only the research team can see it. Notes, tapes and transcripts will only have codes and not names in order to safeguard confidentiality. At the end of the research the tapes will be erased. At the end of the study the database will have any features that could be used to identify an individual removed. All data will be treated in accordance with the current Data Protection Act.

What happens in the event that poor practice is revealed?

In the event that revelations of poor practice (by yourself or others) are revealed during the interview, normal NHS Trust, University and Professional standards and policies will apply. The information may be passed to your line manager who will then take responsibility for any subsequent action in line with policy.

What if something goes wrong?

Whilst it is not anticipated that there are any risks of taking part in this study-In the event that something does go wrong and you are harmed during the research study there are no special compensation arrangements. If you are harmed and this is due to someone's negligence then you may have grounds for a legal action for compensation, but you may have to pay your legal costs.

What if I wish to complain?

Please raise any concerns or questions with Rose Webster , Education and Practice Development Lead, University Hospitals of Leicester and Lead Researcher for this study on (0116) 2583060. If you have any complaints please contact Eleanor Meldrum- Assistant Chief Nurse-University Hospitals of Leicester – in writing, via the internal e-mail system or through switchboard

What will happen to the results of the study?

The results will be made available following the completion of the study in 2018. We will provide a summary and you will be able to receive a copy of this if you wish.

Who is organising and funding the study?

The study is being carried out without additional funding and is organised by the researcher who is employed by University Hospitals of Leicester NHS Trust. The study has been approved by the Ethics Committee of De Montfort University and the Research and Development office at the Trust .

Contact for further information

If you would like any further information about the study please contact :

Rose Webster. Education and Practice Development Lead. Acute Care Division UHL. Tel: (0116) 2583060 or e- mail Rose.Webster@uhl-tr.nhs.uk .

Thank you for taking the time to read this Information Sheet.

.....

REPLY SLIP

An exploratory study to examine the lived experience of newly appointed Health Care Assistants (HCAs) during their first six months in a role within an Acute Hospital setting

I have read the information about the above study and I would like to express an interest in taking part in this study.

I understand that I will have further opportunity to find you more about the study before I decide to take part and that I am under no obligation to do so.

Name:

Area of work (Ward number and Hospital site- e.g. ward 32 Glenfield Hospital)
.....

SignatureDate.....

Please return this form in the envelope provided to:

Rose Webster, Education and Practice Lead

Glenfield Hospital site, Groby Road,Leicester LE3 9QP

You will be contacted through your UHL e-mail account within the next 2 weeks for further information about the study. You can also e-mail me on my UHL e-mail address to let me know that you are interested in taking part. Rose.webster@uhl-tr.nhs.uk

Appendix 7: Study Consent Form



University Hospitals of Leicester **NHS**
NHS Trust

Glenfield Hospital
Groby Road
Leicester
LE3 9QP

Tel: 0116 2871471

CONSENT FORM

Title of Project: An exploratory study to examine the lived experience of newly appointed Health Care Assistants (HCAs) during their first six months in a role within an Acute Hospital setting

Please initial box

1. I confirm that I have read and understand the information sheet dated 12/01/15 (Version 1) for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily.

☐

2. I understand that my participation is voluntary and that I am free to withdraw at any time, without giving any reason, with no consequences for my employment at The University Hospitals of Leicester NHS Trust.

☐

3. If I am selected I agree to be interviewed for the above study and for the interviews to be audio-taped.

☐

4. I agree for my words to be anonymised and used as non-identifiable quotations in the presentation of the research report and in any publications arising from the research

☐

5. I understand that the data collected during the study may be looked at by a supervisor From De Montfort University. I give my permission for this.

☐

AT INITIAL RECRUITMENT ONLY :

6. I understand that I will be approached to take part in a further interview in 4-6 months time, And that I will be asked to give further written consent prior to any second interview taking place.

☐

7. I agree to take part in the above study.

☐

Name of Participant

Date

Signature

Name of Person taking consent
(if different from researcher)

Date

Signature

Researcher

Date

Signature

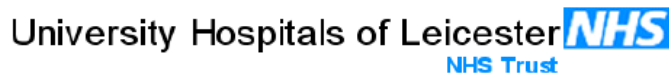
When completed, 1 for the member of staff, 1 for the researcher file.

CONSENT FORM

Version 1 12/11/14.

I

Appendix 8: HCA Induction Programme



UHL HCA Care Certificate Induction Programme 2015

May 2015

Facilitated by the Education & Practice Development Teams

Dates	Topic Programme
Day 1	Welcome and Introduction to the Trust. The Role of the HCA Introducing the Care Certificate Patient Journey, Code of Conduct
Day 2	Infection Prevention Tissue Viability Patient Hygiene
Day 3	EWS and Vital Signs
Day 4	Care of the Patient with Diabetes
Day 5	Care of the Patient with Altered Behaviour
Day 6	AM Observations of Care, Challenging Poor Practice PM Continence
Day 7	Care of the Dying
Day 8	Dementia, Learning Disabilities
Day 9	AM Safeguarding, MCA, DOLS and Consent PM Training Opportunities
Day 10	Making Every Contact Count – Smoking, Alcohol Liaison
Day 11	Presenting Group Projects Presentation of Care Certificates

Appendix 9: Demographic Questionnaire

Name:

QUESTIONNAIRE

An exploratory study to examine the lived experience of newly appointed Health Care Assistants (HCAs) during their first six months in a role within an Acute Hospital setting

The following questionnaire is designed provide us with information about you at the start of your transition to becoming a Health Care Assistant (HCA) within an Acute Hospital Trust.

All data will be treated anonymously once entered on the computer data base. However, we need to know your details at this stage in order to match your questionnaire with any other data collected from you. Please leave out any sections that you feel uncomfortable with.

About you:

- 1. Age**
- 2. Gender**
- 3. Have you ever worked in a health care capacity outside of a hospital setting before?**
(underline appropriate response)
 - YES
 - NO

If YES Please give brief details e.g. type of work and for how long:

- 4. Have you ever worked in a health care role in an NHS hospital setting before?**
(underline appropriate response)
 - YES
 - NO**If YES Please give brief details e.g. name of hospital, type of ward and for how long :**

- 5. Where are you working as an HCA within the University Hospitals of Leicester (UHL) NHS Trust? Please give ward number and Hospital site**

Appendix 10: Ethical issues and how they were addressed by the research method.

Ethical issues identified	How these were addressed
<ul style="list-style-type: none"> The researcher works in the Trust where the HCAs will be working and some may be known to the researcher. Potential for perceived coercion/ pressure to participate. 	<ul style="list-style-type: none"> Access to potential respondents was made through the Education and Practice Development Nurse or the Ward Sister and not the researcher. The researcher only contacted the respondent's once they have indicated an interest in participating in the study. The role of the researcher as a nurse is acknowledged.
<ul style="list-style-type: none"> Recounting personal experiences may cause concern for HCAs who may feel that their responses may be fed back directly to their area of work and may affect their day to day work. 	<ul style="list-style-type: none"> Participants were assured of confidentiality and that their responses will be used for the purposes of the research only and not for any other purpose. Specific written consent was obtained for tape recording. Consent was obtained to use quotations verbatim and assurance given that these would be anonymised.
<ul style="list-style-type: none"> The Interviews may reveal unsafe and or poor practice 	<ul style="list-style-type: none"> It was made clear in the PIS (Appendix 5) and prior to the interview that any unsafe or poor practice would need to be taken forward as part of the researchers Professional Code of Practice.
<ul style="list-style-type: none"> Respondents may wish to withdraw from taking part in the study 	<ul style="list-style-type: none"> Participants were assured that they could withdraw from the study at any time should they wish to do so, without explanation or consequence and that any data already collected will not be used without their express permission to do so. However it was made clear that information already anonymised and analysed would be retained.
<ul style="list-style-type: none"> Parts of the interview may cover subject matter that is upsetting to those taking part 	<ul style="list-style-type: none"> The researcher has experience in conducting research interviews and would have stopped the interview to support the respondent if they become upset. There was an option to end the interview and /or reconvene at another time. The normal support mechanisms for clinical staff were also available (e.g. AMICA) .

Ethical issues identified	How these were addressed
<ul style="list-style-type: none"> • Respondents need to be prevented from feeling pressured or coerced into taking part in the study. 	<ul style="list-style-type: none"> • Potential respondents were identified by either the Trusts HR department or the education and practice development Team neither of whom have any line management responsibilities for the Participant or any vested interest in the study. They were initially approached by the education teams running the induction programme.
<ul style="list-style-type: none"> • The researcher is a senior nurse within the trust and respondents may have felt intimidated by the hierarchal difference which may have also influenced their responses to the interview questions. 	<ul style="list-style-type: none"> • The remit of the researcher was clearly explained – in particular the fact that the researcher held no line management responsibilities for the participants. • The HCAS were exposed to members of the education and practice development team prior to the interviews and so hopefully did not feel intimidated being interviewed by a member of that team.
<ul style="list-style-type: none"> • Informed consent is a pre requisite of all research 	<ul style="list-style-type: none"> • The potential respondent was given the participant information sheet to read and consider. They had at least 2 days to decide if they wished to take part. Only after the potential respondents had contacted the researcher were arrangements made to consent respondents into the study. This took place at a time convenient to the respondent and was carried out by the researcher. All participants who agreed to be interviewed were asked to sign a consent form indicating their willingness to be interviewed, that they had read and understood the aims of the study and what was expected of them and to indicate their consent to the interview being audio-taped (See Consent form Appendix 6). • There was specific consent for audio taping of the interviews.
<ul style="list-style-type: none"> • Confidentiality in research 	<ul style="list-style-type: none"> • Confidentiality was assured and maintained at all times. Respondents were given a pseudonym and this appeared on all transcripts. No respondent will be identifiable in any documentation relating to the study. The interview tapes were all transcribed by the researcher.

Ethical issues identified	How these were addressed
<ul style="list-style-type: none"> Storage of data 	<ul style="list-style-type: none"> All data was encrypted and stored on a password protected computer. Access was restricted to the researcher only. Data will be kept for the duration of the study only. Upon completion of the study all data will be destroyed.
<ul style="list-style-type: none"> Access to study findings and Dissemination of findings 	<ul style="list-style-type: none"> Participants will have access to the full report once written.
<ul style="list-style-type: none"> Safety of the researcher 	<ul style="list-style-type: none"> All interviews were conducted at a time and place convenient to the participants. However this was always on Hospital premises The Hospital Trusts Lone Worker Policy was adhered to at all times.
<ul style="list-style-type: none"> Non- completion of the research and therefore potential for participants to feel that they have used their time inappropriately 	<ul style="list-style-type: none"> The researcher had the full support of her line manager to undertake this research and an acknowledgment, discussed at appraisal, that time would be needed during the analysis and writing up stage.

Appendix 11: Initial Interview Guide

An exploratory study to examine the lived experience of newly appointed Health Care Assistants (HCAs) during their first six months in a role within an Acute Hospital setting

Semi Structured Interview Guide. Initial Interview.

- Thank you for taking part in the study
- Introductions and recap about the study- check understanding
- Recap about the interview- audio taped, duration of an hour or so.
- Ground rules. Any questions / concerns
- Treatment of the information= anonymity, opportunity to read transcript
- Written Consent for interview and audiotape.

Themes

- Tell me a bit about yourself
 - Background
 - Life journey
 - Decision to become an HCA in acute care – influences/expectations
- I would like to hear about your experiences over the last few weeks- where would you like to begin?
- Prompt:-Tell me about ...
 - What's been happening?
 - What has it felt like?
 - What is important to you?
 - What has made a difference?
 - What has been good / not so good
 - Hopes and fears
 - Expectations

Probes:

- Can you tell me a bit more about that
- Why do you say that?
- Can you give me an example to illustrate that?
- How did that make you feel?

At the end of the interview ask if there are is anything else that the participant would like to talk about that has not been covered or anything that they would like to go back to.

Thank them for sharing their experiences and clarify the practicalities of the second interview

Appendix 12: Interview guide- Six Month Interview

An exploratory study to examine the lived experience of newly appointed Health Care Assistants (HCAs) during their first six months in a role within an Acute Hospital setting

Semi Structured Interview Guide. Second (6 months) Interview.

- Thank you for taking part in this second interview
- Recap about the study- check understanding
- Recap about the interview- audio taped, duration of an hour or so.
- Ground rules. Any questions / concerns
- Treatment of the information= anonymity, opportunity to read transcript
- Written Consent for interview and audiotape.

Themes

- So how are you? What's been happening- Where would you like to begin, Tell me about
- I would like to hear about your experiences since the last interview.
Prompts
 - What has it been like?
 - How did you feel ?
 - What has made a difference?
 - What has been good / not so good
 - Hopes and fears
 - What is important to you?
 - Expectations
 - Anything you would like to say to the next group of HCAs?

Probes:

- Can you tell me a bit more about that
- Why do you say that?
- Can you give me an example to illustrate that?
- How did that make you feel?

At the end of the interview ask if there are is anything else that the participant would like to talk about that has not been covered or anything that they would like to go back to.

Thank them for sharing their experiences and clarify the practicalities for feeding back the research report summary at the end of the study

Appendix 13: 3 - 4 week interview– Analysis themes identified by Participants- first order participant constructs – Descriptive Analysis

<ul style="list-style-type: none"> -Feeling lost -Not knowing where things are -Who is who and who does what? -I don't know the rules -Not wanting to break anything -Scared of touching things -Getting in the way -Not wanting to rock the boat - Waiting for things to happen during a long recruitment process -Induction programme disorganised -Care Certificate confusing -The first two weeks were really confusing -Holding back - watching and listening -There was a clear trigger point that led to the application for the post -Watching how Nurses work - I could do that -Wanting to give something back to the NHS - Seeing this role as a testing ground for future career moves -Is this for me? -Preparing for the role and seeing the role as a Journey -I am going to make the most of this opportunity -Thinking about a career in nursing -Wanting to learn in order to get on -It's down to me to learn -Determination to succeed -Clear milestones -The future looks good -Focus on mastering clinical skills -Want to be able to do things on my own -Feeling like an impostor- would be found out -Relying on the uniform to me the right to be here -The uniform makes me feel important -Feeling like an observer looking on -Outside my comfort zone -Self-doubt initially -When you put the uniform on people expect you to be an HCA. -The supernumerary badge is irrelevant -Its different to my previous role -I knew what I was doing in my previous role 	<ul style="list-style-type: none"> -The reality of acute care compared to previous caring role -Reality of role – not like it is on TV. -Its not like a normal job -The patients are complicated -Stories about patients they found challenging -Not sure what was expected of me in the role at the start -Caring is fundamental to the role – bring this skill with me -I am a person who cares for others -Significance of patients medical condition- both physical and medical health -Telling stories about caring for patients who are dying -Relating to their own experiences with death and dying -Going into it blind – not sure what to expect -Positive Significance of the ward team – friendly and welcoming -Felt more on their own in community caring roles -Everyone else seems to know what to do -There's always others to turn to here -Good to be working with others around them -Wanting to be part of the team -Wanting to fit in -Couldn't find the way in to the ward at first -Didn't know the door codes/ find the key -Not wanting to rock the boat -Positive Significance of the buddies attitude -Working round family -Feedback is important -Family members are proud of them -Really excited at the beginning- particularly on the first day -First day daunting/ scary /frightening -Felt sick with nerves on the first day on the ward -Chose emotional words to describe things -Had to make changes in terms of day to day living -Impact on child care -Less time for themselves -Having to be more organised
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<ul style="list-style-type: none"> -The reality of this role compared to previous job -Impact on family members daily life -Looking in from the outside -Learning through doing -It's a different language 	<ul style="list-style-type: none"> -Long shifts a challenge -Encouragement of friends and family to apply -Support of family in first few weeks -Making friends on the induction programme -Joining the NHS
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Appendix 14: 3 - 4 week interview- Analysis themes; Broader analysis themes and Interpretative Themes

Interpretative Theme N=9	Broader analysis theme N=25	Analysis themes N=81
Immobilised by confusion	<p>a. Recruitment and induction process felt disorganised</p> <p>b. Surrounded by confusion in first 2-3 weeks</p> <p>c. Fearful of doing something wrong.</p>	<p>Feeling lost, not knowing where things are</p> <p>Who is who and who does what?</p> <p>Not wanting to break anything</p> <p>Scared of touching things</p> <p>Getting in the way</p> <p>Not wanting to rock the boat</p> <p>Waiting for things to happen during a long recruitment process</p> <p>Induction programme felt disorganised</p> <p>Care Certificate confusing</p> <p>The first two weeks were really confusing</p> <p>Holding back- watching and listening</p> <p>Going into it blind – not sure what to expect</p>
Being Proactive	<p>a. Deliberately testing themselves</p> <p>b Now is the right time for me to be doing this .</p> <p>c Ambitious and wanting to learn</p> <p>d This is part of my master plan</p> <p>e Want to be doing things</p>	<p>There was a clear trigger point that led to the application for the post</p> <p>Watching how Nurses work - I could do that</p> <p>Wanting to give something back to the NHS</p> <p>Seeing this role as a testing ground for future career moves</p> <p>Thinking about a career in nursing</p> <p>Is this for me?</p> <p>Preparing for the role and seeing the role as a journey</p> <p>Wanting to learn in order to get on</p> <p>Its down to me to learn</p> <p>Determination to succeed</p> <p>Clear milestones</p> <p>The future looks good</p> <p>Focus on mastering clinical skills</p> <p>Want to be able to do things on my own</p> <p>Learning through doing</p> <p>I am going to make the most of this opportunity</p>

Interpretative Theme N=9	Broader analysis theme N=25	Analysis themes N=81
I don't have the right to be in this role	<ul style="list-style-type: none"> a. Self doubt b. Being an impostor c. Hiding behind the uniform d Defining themselves by previous role 	<ul style="list-style-type: none"> Feeling like an impostor- would be found out Relying on the uniform to give me the right to be here The uniform makes me feel important Self doubt initially When put the uniform on, people expect you to be an HCA. Supernumerary badge irrelevant. Its different to my previous role I knew what I was doing in my previous role- didn't here Outside my comfort zone
Feeling an outsider	<ul style="list-style-type: none"> a Not knowing the rules b Fearful of crossing boundaries they could not see c On the outside looking in 	<ul style="list-style-type: none"> Feeling like an observer looking on Looking in from the outside Couldn't find the way in to the ward at first Didn't know the door codes/ find the key Every one else seems to know what to do I don't know the rules It's a different language Joining the NHS
What I'm doing is important	<ul style="list-style-type: none"> a Contrasting with what they know b. Impact of the case load of patients c. Caring remains central d Uncertainty about what the role is 	<ul style="list-style-type: none"> The reality of acute care compared to previous caring roles The reality of this role compared to previous job Reality of role – not like it is on TV. Its not like a normal job Patients are complicated Stories about patients who are challenging Not sure what was expected of them in the role at the start Caring is fundamental to the role – bring this skill with me I am a person who cares for others Significance of patients medical condition- both physical and medical health Telling stories about caring for patients who are dying Relating to their own experiences with death and dying Going into it blind – not sure what to expect

Interpretative Theme N=9	Broader analysis theme N=25	Analysis themes N=81
Influence of pre-existing support structures	<p>a Impact on those around them</p> <p>b Valuing support of friends and family</p>	<p>Working round family</p> <p>Impact on childcare</p> <p>Encouragement of friends and family to apply</p> <p>Support of family in first few weeks</p> <p>Family members are proud of them</p> <p>Impact on family members lives</p> <p>Family are behind them during first few weeks</p>
Significance of others at work	<p>a. Identifying new support networks</p> <p>b. wanting to belong</p>	<p>Positive Significance of the ward team – friendly and welcoming</p> <p>Felt more on their own in community caring roles</p> <p>There's always others to turn to here</p> <p>Making friends on the induction programme</p> <p>Good to be working with others</p> <p>Wanting to fit in</p> <p>Not wanting to rock the boat</p> <p>Wanting to be part of the team</p> <p>Positive Significance of the buddies attitude</p> <p>Feedback is important</p>
Emotional Impact	<p>a. Vivid emotions at the beginning</p> <p>b. Realising the emotional significance of the role</p>	<p>Really excited at the beginning- particularly on the first day.</p> <p>First day daunting/ scary /frightening</p> <p>Felt sick with nerves</p> <p>Chose emotional words to describe things</p>
Personal sacrifices for the greater good	<p>a. Had to make changes in terms of day to day living</p> <p>b . Personal impact of doing the job</p>	<p>less time for themselves</p> <p>Having to be more organised</p> <p>Long shifts a challenge</p> <p>Feeling tired and exhausted</p>

Appendix 15: 3- 4 week interview: Sub and Key Interpretative themes

Key Interpretative Theme	Sub Interpretative Theme
Ability to move forward	Immobilised by confusion Being Proactive
My place in this role	I don't have the right to be in this role Feeling an outsider What I'm doing is important
I am not doing this alone	Influence of pre-existing support structures Significance of others at work
Personal consequences	Emotional impact Personal sacrifices for the greater good

Appendix 16: The Spread of themes across the 3 - 4 week interviews.

Broader analysis theme N=25	NVivo Sources- the number of participants mentioning the theme (N=12)	NVivo- The number of coded references to this theme across the 12 interviews
a. Recruitment and induction process felt disorganised	12	25
b. Surrounded by confusion in first 2-3 weeks	7	13
c.. Fearful of doing something wrong.	8	17
a. Deliberately testing themselves	7	8
b Now is the right time for me to be doing this .	9	16
c Ambitious and wanting to learn	10	19
d This is part of my master plan	10	22
e Want to be doing things	7	10
a. Self doubt	7	11
b. Being an impostor	8	15
c. Hiding behind the uniform	9	16
d Defining themselves by previous role	6	8
a Not knowing the rules	7	10
b Fearful of crossing boundaries they could not see	8	17
c On the outside looking in	7	12
a Contrasting with what they know	6	8
b. Impact of the case load of patients	8	17

c. Caring remains central	10	26
d. Uncertainty about what the role is	12	36
a. Impact on those around them	9	15
b. Valuing support of friends and family	11	21
a. Identifying new support networks	12	32
b. Wanting to belong	7	11
a. Vivid emotions at the beginning	7	8
b. Realising the emotional significance of the role	6	10
a. Had to make changes in terms of day to day living	9	11
b. Personal impact of doing the job	7	14
<p>Whilst the prevalence of a theme throughout the interviews and the proportion of each interview devoted to each theme was not necessarily an indicator of that themes significance- ie more instances did not necessarily mean that the theme was more crucial (Braun and Clarke 2006) it was useful to get an appreciation of the spread of the themes throughout the interviews (Bazeley and Jackson 2013).</p>		

Appendix 17: Six month interview – Themes identified by Participants- first order constructs – Descriptive Analysis

<ul style="list-style-type: none"> - My previous experience has helped me - Similarities and differences with my previous role - Telling stories about where they have made a difference to a patient - This role lets me care for patients - Enjoy being with patients - Patients are still basically the same here - I try and do things to make my life a bit easier - You have to keep to keep asking questions - Using my own initiative - I don't say yes to everything now - Starting to work out how the team works - Know who the good mentors are and I go to them - Know who the good nurses are - The atmosphere is different depending who is on duty - Different people expect different things from me - Have to work differently depending who is on the shift - Aware of the ward politics - Think I have come a long way as a person in the last six months - Feel that I am a changed person - Feel more confident at approaching people - I can touch the patients now - Feel so much more confident now - People at home have told me that I have changed - Sometimes I don't recognise myself - I am not sure how the Care Certificate helped me - Have learnt most by doing - Comparing what they do with the RN role - Sometimes think I am doing the RNs job - The long shifts are difficult for me - Moved wards because of shift patterns - Don't have to ask so many questions now - Can get left on my own now - Feel that I am trusted to get on with things now - Feel that the team trust me - The team can rely on me now - I am working as part of the team 	<ul style="list-style-type: none"> - Still get scared at times - Looking back it was scary at the beginning - Family are proud of me - Feel proud of myself - Acknowledge the journey I have come on - Feel I am doing OK at the moment - It's all good at the moment - I have no regrets - This is a great role - Wish had done this before - Think I'll stay as I am for a while - There's still so much I have to learn - Feel OK to stay as an HCA at the moment - Taking it one day at a time - It's not always like they teach you in the classroom - Didn't realise that it would be quite like this - There are things wrong with the system - I am starting to see things for what they are - It's really busy- but I quite like that - No day is the same - Feel I know what's going on now - Organisation out of chaos - It is important to understand the medical condition of the patient - Patients with mental health problems are a challenge - Need to know what's wrong with the patient - I need to know more about medical conditions - I didn't really need to know what was wrong with patients before - I am now caring for very sick patients - New experiences with death and dying - Sense of achievement at doing something well - Keeping a sense of humour - Support from the team is important - Feels part of the team - Feel I belong here - I have friends in the team now - Some of us go out socially - The Ward Sister has been significant - More emotionally involved with patients than I thought I would be - I have rethought my plans a bit
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<ul style="list-style-type: none"> -I can work independently now -Values feedback from particular people -Families support is still important - I am not sure how the Care Certificate helped me - I am settled here for now - Don't feel lost any more - On a voyage of discovery -No longer looking for order – there isn't any - No longer waiting in the wings/on the sideline - You cant do things how we were taught - Not ready to challenge that yet - I' m playing the part now - Families can be stressful - its good to talk things through - The team have supported me - I was like a duck out of water - I am really enjoying it now - The ward have sussed me out - I really had no idea at the beginning - I have found myself -The team are getting the measure of me 	<ul style="list-style-type: none"> -You can't please all the people all the time -I like the unpredictability -I know what needs doing now <ul style="list-style-type: none"> - Examples of meeting a challenge - I'm not fully there yet - You have to push yourself - Need to ride things through - Feel I'm being tested as a person - You have to be open to things - Not ready to rock the boat yet - Going with the flow -My Buddy gets me . - Support from the ward Sister -There is always someone to ask here - The team know me now - I was lost at the beginning - Hospital environment not what I'm used to - My family have been great - Taking it one day at a time - I need to give myself time - I plan to do more clinical skills in the future - Potential for missing an unwell patient - I've got my child care sorted now
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Appendix 18: Six month Interview: Analysis themes; Broader analysis themes and Interpretative themes

Interpretative Theme N= 10	Broader analysis themes N= 29	Analysis themes N= 115
Creating opportunities	<p>Maximising learning</p> <p>Creating situations for their own benefit</p> <p>Planning ahead</p>	<p>You have to keep asking questions Know who the good mentors are and go to them Have learnt most by doing</p> <p>I try and do things to make my life a bit easier Using my own initiative You have to push yourself I don't say yes to everything now I have rethought my plans a bit There's still so much I have to learn I plan to do more clinical skills in the future On a voyage of discovery I'm not fully there yet</p>
Finding my place in the team	<p>Working out the characteristics of the team</p> <p>Fitting around the team dynamics</p>	<p>Different people expect different things from me Have to work differently depending who is on the shift The atmosphere is different depending who is on duty You cant please all the people all the time Aware of the ward politics Know who the good nurses are Starting to work out how the team works Support from the ward Sister There's always someone to ask here My Buddy gets me The ward have sussed me out too</p>

Interpretative Theme	Broader analysis themes	Analysis themes
All in good time	<p>Going with the flow</p> <p>Not rushing things</p>	<p>You have to be open to things</p> <p>Need to ride things through</p> <p>Not ready to rock the boat yet</p> <p>Going with the flow</p> <p>Taking it one day at a time</p> <p>I need to give myself time</p> <p>I'm settled here at the moment</p>
Facing the reality of the role	<p>Appreciating the uniqueness of the role</p> <p>Comparing themselves with the registered nurses role</p> <p>Voicing ways that the system isn't perfect</p> <p>Need to understand how the patients medical condition impacts on their role as an HCA</p>	<p>Its not always like they teach you in the class room</p> <p>Similarities and differences with my previous role</p> <p>More emotionally involved with patients than thought I would be</p> <p>Hospital environment is not what I'm used to</p> <p>My previous experience has helped me</p> <p>Didn't realise that it would be quite like this</p> <p>I really had no idea at the beginning</p> <p>Comparing what they do with the RN role</p> <p>Sometimes think I am doing the RNs job</p> <p>The long shifts are difficult for me</p> <p>Moved wards because of shift patterns</p> <p>I am not sure how the Care Certificate helped me</p> <p>There are things wrong with the system</p> <p>You cant do things how we were taught</p> <p>I am starting to see things for what they are</p> <p>It is important to understand the medical condition of the patient</p> <p>Patients with mental health problems are a challenge</p> <p>Need to know what's wrong with the patient</p>

		<p>I need to know more about medical conditions</p> <p>I didn't really need to know what was wrong with patients before</p> <p>Families can be stressful</p> <p>Potential for missing an unwell patient</p>
Rising to the challenges	<p>Seeing order through the chaos</p> <p>Able to get on with it now</p>	<p>Its really busy- but I quite like that</p> <p>No day is the same</p> <p>I like the unpredictability</p> <p>Feel I know what's going on now</p> <p>Don't have to ask so many questions now</p> <p>Sense of achievement at doing something well .</p> <p>Examples of meeting a challenge</p> <p>I can work independently now</p> <p>I know what needs doing now</p> <p>No longer looking for order- there isn't any</p> <p>Feel I'm being tested as a person</p>
Being allowed in	<p>Feeling valued as one of the team</p> <p>Feeling part of the social network</p> <p>A sense of belonging</p> <p>Getting to be known by the team</p> <p>Feeling supported by the team</p> <p>Being able to see and do things by virtue of their role</p>	<p>Can get left on my own now</p> <p>Feel that I am trusted to get on with things now</p> <p>Feel that the team trust me</p> <p>The team can rely on me now</p> <p>Feels part of the team</p> <p>Feel I belong here</p> <p>I'm playing the part now</p> <p>I was like a duck out of water</p> <p>Don't feel lost any more</p> <p>No longer waiting in the wings/on the side-line</p> <p>Have friends in the team now</p> <p>Some of us go out socially</p> <p>I am working as part of the team</p> <p>Support from the team is important</p> <p>I am now caring for very sick patients</p> <p>New experiences with death and dying</p> <p>I can touch patients now</p> <p>Its good to talk things through</p>

Interpretative Theme	Broader analysis themes	Analysis themes
In a good place	<p>Happy where I am for now</p> <p>Positive outlook</p> <p>Family support structures working</p>	<p>Feel I am doing OK at the moment</p> <p>Its all good at the moment</p> <p>I have no regrets</p> <p>This is a great role</p> <p>Wish had done this before</p> <p>Think Ill stay as I am for a while</p> <p>Feel OK to stay as an HCA at the moment</p> <p>Keeping a sense of humour</p> <p>Settled here for now</p> <p>I am really enjoying it now</p> <p>My family have been great</p> <p>I've got my child care sorted now</p>
Positive affirmation of where I am	<p>The importance of feedback from those they respect</p> <p>Acknowledgement of their own achievements</p>	<p>The Ward Sister has been significant</p> <p>Values feedback from particular people</p> <p>Families support is still important</p> <p>Family are proud of me</p> <p>Acknowledge the journey that I have come on</p> <p>Previous experience has helped me</p> <p>Still get scared at times</p> <p>Looking back it was scary at the beginning</p> <p>I really had no idea at the beginning</p> <p>Feeling proud of myself</p>
A changed person	<p>Success measured by increased self confidence</p> <p>A noticeable difference in me</p> <p>Finding myself</p>	<p>Feel more confident at approaching people</p> <p>Feel so much more confident now</p> <p>People at home have told me that I have changed</p> <p>Sometimes I don't recognise myself</p> <p>Feel I am a changed person</p> <p>Think I have come along way as a person in the last six months.</p> <p>I was lost at the beginning</p> <p>I have found myself</p>

Interpretative Theme	Broader analysis themes	Analysis themes
I am still a carer.	<p>Caring and compassion remain important</p> <p>It is important that what I do makes a difference to patients</p>	<p>Telling stories about where they have made a difference to a patient</p> <p>This role lets me care for patients</p> <p>Enjoy being with patients</p> <p>Patients are still basically the same here</p> <p>More emotionally involved with patients than thought I would be</p>

Appendix 19: The Spread of themes across the six month interviews

Broader analysis theme N=10	NVivo Sources- the number of participants mentioning the theme (N=10)	NVivo- The number of coded references to this theme across the 10 interviews
Maximising learning	8	15
Creating situations for their own benefit	9	28
Planning ahead	8	18
Working out the characteristics of the team	7	13
Fitting around the team dynamics	5	6
Going with the flow	5	5
Not rushing things	4	6
Appreciating the uniqueness of the role	10	21
Comparing themselves with the registered nurses role	6	12
Voicing ways that the system isn't perfect	8	18
Need to understand how the patients medical background impacts on their role as an HCA	9	18
Seeing order through the chaos	9	11
Able to get on with it now	10	25
Feeling valued as one of the team	10	32
Feeling part of the social network	4	6
A sense of belonging	9	16
Getting to be known by the team	4	6
Feeling supported by the team	9	22

Being able to see and do things by virtue of their role	8	28
Happy where I am for now	3	6
Positive outlook	10	37
Family support structures working	8	10
The importance of feedback from those they respect	6	20
Acknowledgement of their own achievements	8	18
Success measured by increased self confidence	8	11
A noticeable difference in me	6	12
Finding myself	4	5
Caring and compassion remain important	9	21
It is important that what I do makes a difference to patients	4	7

Appendix 20: Consistent Themes Across the Two Interviews

<u>3 - 4 weeks</u>	<u>6 months</u>	<u>Consistent theme across the two interviews.</u>
Going into it blind- not sure what to expect	I really had no idea at the beginning Didn't realise that it would be quite like this	No idea what was expected of me at the beginning
First day daunting/ scary/ frightening	Looking back it was scary at the beginning	Scary at the beginning
Its different to my previous role The reality of this role compared to previous job	Similarities and differences with my previous role Hospital environment not what I'm used to	Contrasting to previous role
Care Certificate confusing	I am not sure how the Care Certificate helped	Care Certificate Confusing
Seeing the role as a journey	On a voyage of discovery Acknowledge the journey I have come on	On a journey (of self discovery)
Outside my comfort zone	I was like a duck out of water	Outside of comfort zone at the beginning
There's always others to turn to here	There is always someone to ask here	It feels like there is always someone to turn to
Feeling Lost, not knowing where things are	I was lost at the beginning	Feeling lost at the beginning
Not wanting to rock the boat	Not ready to challenge that yet Not ready to rock the boat	Not wanting to rock the boat
The future looks good	Its all good at the moment Feel I am doing OK at the moment	Feeling positive
Learning through doing	Have learnt most by doing	Learning through doing

<u>3 - 4 weeks</u>	<u>6 months</u>	<u>Consistent theme across the two interviews.</u>
Practical support of family in the first few weeks Family behind them during the first few weeks Working round family Impact on childcare Impact on family members lives	Families support is still important My family have been great	Families support has been significant
Its down to me to learn Determination to succeed I am going to make the most of this opportunity	You have to keep asking questions Using my own initiative You have to push yourself You have to be open to things	You have to make the most of things
Significance of patients medical condition – both physical and mental health The reality of acute care compared to previous caring roles Patients are complicated	Need to know what's wrong with the patient Its important to understand the medical condition of the patient Patients with mental health problems are a challenge I didn't really need to know what was wrong with the patients before Potential for missing an unwell patient	Medical significance of the patients- this is important stuff
Telling stories about caring for patients who are dying Relating to their own experiences with death and dying	I am now caring for very sick patients New experiences with death and dying	Being exposed to death and dying is a new experience
Caring is fundamental to the role- bring this with them Identify themselves as carers	This role lets me care for patients Enjoy being with patients	Caring is fundamental to what I do in this role
Family members are proud of me	Family are proud of me	Family are proud of me
Positive significance of the ward team- friendly and welcoming	The team have supported me	Positive significance of the ward team
Long shifts a challenge	The long shifts are difficult for me Moved wards because of shift patterns	Long shifts have been difficult to cope with

Appendix 21: The Lived Experience – consistent and evolving themes across the six month time period.

Colour Key: - Descriptive Themes that developed or diminished (evolved) across the six month time span - Themes overarching/ consistent across the two interviews (from Table 6.1) - Interpretation – the lived experience		
3-4 weeks	6 months	Interpretative theme for the lived experience
Feeling like an observer looking on Standing back- watching and listening Looking in from the outside Didn't know the door codes/ find the key Outside of my comfort zone at the beginning	No longer waiting in the wings/ on the sideline I am playing the part now	Finding their way in
I don't know the rules It's a different language Feeling like an impostor- I would be found out Getting in the way Relying on the uniform to give me the right to be here No idea what was expected of me at the beginning	Feel I belong here	Increased sense of Legitimacy / belonging
Not wanting to break anything Scared of touching anything Scary at the beginning Not wanting to rock the boat initially	I can touch patients now	Now feel able to impact on/ engage with the situation they are in – they are in the picture
Couldn't find my way to the ward at first Feeling lost Not knowing where things are Feeling lost at the beginning	Don't feel lost any more I have found myself People have told me that I have changed, Sometimes I don't recognise myself, I have found myself A perceived increase in confidence On a journey of self discovery	Finding themselves

3-4 weeks	6 months	Interpretative theme for the lived experience
First two weeks were really confusing Care Certificate confusing	Organisation out of chaos No longer looking for order- there isn't any	Seeing that they can cope with the unpredictability
Reality of the role- its not like on TV Its not like a normal job	Telling stories about when they have made a difference to a patient Its not like a normal job Being exposed to death and dying	Appreciating the unique importance/ significance of the role they are doing. Medical significance of the patients
Waiting for things to happen during a long recruitment process. Everyone else seems to know what to do Not sure what was expected of them at the start I knew what I was doing in my previous role- I don't here Who is who and who does what	I feel I know what's going on now I know what needs doing now I don't have to ask so many questions now	Now have the knowledge of the work place
When you put the uniform on people expect you to be an HCA The uniform makes me feel important	Significance of role- what I do is important	No longer relying on external label/ badge of honour to feel importance of the role – it is what <u>they</u> <u>do</u> / what they have become
Self-doubt initially	I feel so much more confident now	Self belief
Stories about patients who are challenging	Examples of meeting a challenge	Equipped to deal with what the job brings
Seeing this role as a testing ground for future career in nursing Is this for me?	Feel OK to stay as an HCA at the moment I have rethought my plans a bit I have no regrets , Wish I'd done this before Feeling positive	Where I am now is actually OK


3 – 4 Weeks	6 months	Interpretative theme for the lived experience
Less time for themselves Feeling tired and exhausted , Having to be more organised	Its all good at the moment Feel I am doing OK at the moment	Adjusting to demands of role
Having clear milestones – wanting to get going	Going with the flow I am settled here for now Think ill stay as I am for a while Taking it one day at a time I need to give myself time	Gradually taking stock- slowing down the pace – (expectations of moving on)
Focus on mastering clinical skills	I plan to do more clinical skills, but in the future .	Other things assuming priority over clinical skills over the six months Change in priorities over the 6 months
Want to be able to do things on my own	Can get left on my own now I can work independently now The team can rely on me now	Sense of independence/ reliability
Its down to me to succeed I am determined to succeed I am going to make the most of this opportunity	You have to keep asking questions Using my own initiative You have to push yourself You have to be open to things Keeping a sense of humour	Making it happen You have to make the most of things
Felt more on their own in community caring role Good to be working with others	Its good to talk things through I have friends in the team now Some of us go out socially	Importance of developing relationships/ significance of others. It feels like there is always someone to turn to


3-4 weeks	6 months	Interpretative theme for the lived experience
Caring is fundamental to the role- bring this with them	Telling stories of when they have made a difference to a patient Patients are still basically the same here	Realisation of core values of caring and the significance of this to them Caring is fundamental
Wanting to be part of the team	Starting to work out how the team works The team know me now Feel that the team trust me The ward team have sussed me out The team are getting the measure of me I am working as part of the team	Being accepted and supported by the team Positive significance of the ward team
Positive significance of the Buddies attitude	My Buddy gets me	Attitude of Buddy is important
Encouragement of friends and family to apply for the role	Family are proud of me Families support has been consistent	Family are a significant source of support Families support has been significant
		Comparing and contrasting to previous roles
		The long shifts have been difficult to cope with
		Learning through doing


Appendix 22: Themes unique to the time of the interview
3 - 4 weeks
There was a clear trigger point that led to the application for the post, Wanting to give something back Preparing for the role Supernumerary badge irrelevant


Appendix 23: Inhibitors and Facilitators influencing the lived experience


Implications for practice as identified by the researcher and through initial discussion with members of the Trust Education and Practice Development team.


		INHIBITORS 	Implications for practice
THEME	Sub theme	Lived Experience	Improving the lived experience
5.4.2.1. Key theme 1.1: Ability to move forward	Immobilised by confusion	Not knowing what was supposed to happen between the job offer and starting in the job	<ul style="list-style-type: none">• Clear communication between HR and the ward manager around the recruitment process and time scales – a named point of contact for the time between job offer and start date.
		Couldn't make any order of it at all in first few days	<ul style="list-style-type: none">• Orientation to the ward before starting first shift• Overview of a typical shift- what happens when- prior to start date• Pictures of who's who in uniform
		Scared to touch anything in case they damaged it	<ul style="list-style-type: none">• Opportunity to handle equipment and see how it works

		INHIBITORS 	Implications for practice
THEME	Sub theme	Lived Experience	Improving the lived experience
5.4.2.2. Key theme 1.2: My place in this role.	I don't have a right to be in this role.	<ul style="list-style-type: none"> • Feeling a fraud in the uniform 	<ul style="list-style-type: none"> • Wearing their uniform in the induction programme so get used to it- feel they belong in it.
		<ul style="list-style-type: none"> • Feeling they are not good enough to be in the role 	<ul style="list-style-type: none"> • Acknowledging that it is normal to lack confidence- doing a ' Hopes and Fears ' session as part of the induction programme – sharing experiences/ feelings • Inviting experienced HCA to the induction programme to talk about their journey
	Feeling an outsider	<ul style="list-style-type: none"> • Not knowing the names of things or what things were called • Not knowing door codes 	<ul style="list-style-type: none"> • Providing a list of pictures of things and the names for them, • Providing a list of door codes and phone numbers
	What I'm doing is important	<ul style="list-style-type: none"> • Not realising the true significance/ enormity of their role • Not prepared for working with acutely unwell patients • Realising a need to know about the patient's medical condition • Not prepared for caring for the dying 	<ul style="list-style-type: none"> • Providing information pre and post interview, testimonies from existing HCAs, video clips of HCAs talking about their roles • Need to cover the care needs of acutely unwell and deteriorating patients on the induction programme • Need to cover fundamentals of the patients underlying medical conditions as part of induction to the ward • Need to inform Buddies of this experience so that they can support HCAs in caring for acutely unwell and deteriorating patients

		INHIBITORS 	Implications for practice
THEME	Sub theme	Lived Experience	Improving the lived experience
5.4.2.4. Key theme 1.4: Personal Consequences	Emotional Impact	<ul style="list-style-type: none"> • The first day on the ward was frightening. • First few days were scary 	<ul style="list-style-type: none"> • Make sure the first day/week is talked through as part of induction so they know what to expect. • Have more of the induction programme delivered before starting on the ward. • Ensure Buddy is on duty on the first day • Have a debriefing session to talk through experiences of first few days
	Personal Sacrifices for the greater good.	<ul style="list-style-type: none"> • Feeling exhausted and tired • 12 hour shifts were difficult 	<ul style="list-style-type: none"> • Consider giving short day shifts initially to get used to the pace and workload • Discuss strategies to cope with the long shift- learning from others
5.5.2.1. Key theme 2.1: Making this work	Creating opportunities	<ul style="list-style-type: none"> • Team members responded to them in different ways and expected different things of them. 	<ul style="list-style-type: none"> • Teams to be aware of how team dynamics can impact on the experience of the HCA. • Development of the ward as a learning environment-a community of practice.
5.5.2.2. Key theme 2.2: Becoming an insider	Facing the reality of the role	<ul style="list-style-type: none"> • Struggling to appreciate the boundaries between their role and that of the registered nurse • Wasn't prepared for all that emotion- getting close to people. 	<ul style="list-style-type: none"> • Need for clear role guidelines • The role of the RN to be covered on HCA induction • Need for consistent clinical leadership at ward level to make expectations clear • Emotional resilience included as part of induction- including self-awareness & coping strategies

		FACILITATORS 	Implications for practice –
THEME	Sub theme	Lived Experience	improving the experience
5.4.2.1. Key theme1. 1: Ability to move forward	Being Proactive	<ul style="list-style-type: none"> Using the HCA role to test the water for going on to be a registered nurse 	<ul style="list-style-type: none"> Using the selection process to identify individuals with a positive outlook and approach. Identify career aspirations with new starters so that they can be given clear realistic advice – structured monitoring and follow up. Recognising that not all HCAs will be the same- some may not be proactive and will need support to reach their potential
		<ul style="list-style-type: none"> Wanting to give something back to the NHS-a catalyst for the job application – wanting this to be known. 	<ul style="list-style-type: none"> Giving HCAs the opportunity to share their stories – their journey so far
		<ul style="list-style-type: none"> Mastering the skill of specific clinical tasks they hadn't performed before 	<ul style="list-style-type: none"> Key programme of clinical skill development in the first few months – mapping skills across to existing competencies.

		FACILITATORS 	Implications for practice –
THEME	Sub theme	Lived Experience	Improving the lived experience
5.4.2.3. Key theme1. 3: I am not doing this alone	Significance of others at work	<ul style="list-style-type: none"> • Welcoming and friendly ward team • Positive significance of the Buddys attitude and approach • The Ward Sister making time to spend with them made a difference 	<ul style="list-style-type: none"> • Feedback to ward teams that their initial reception and welcome makes a difference.. • ensuring that they know to expect a new starter • Feedback to Buddy training that their attitude and approach as well as clinical knowledge and teaching is important • Ward Sisters to invest time in new HCAs
	Support from Friends and family	<ul style="list-style-type: none"> • Families practical support and encouragement is crucial 	<ul style="list-style-type: none"> • Awareness that the HCAS are often juggling complex domestic arrangements – time tables and off duty to be given well in advance to aid forward planning.

		FACILITATORS 	Implications for practice –
THEME	Sub theme	Lived Experience	Improving the lived experience
5.5.2.1. Key theme 2.1: Making this work	Creating opportunities,	<ul style="list-style-type: none"> • Learning the most through doing 	<ul style="list-style-type: none"> • Creating structured learning opportunities and learning programmes within the clinical environment
		<ul style="list-style-type: none"> • Using their initiative and pushing themselves forward 	<ul style="list-style-type: none"> • Listening to the needs of new HCAs. • Supporting those who may not be confident to ask for help and learning opportunities
5.5.2.2. Key theme 2.2: Becoming an insider	Being allowed in	<ul style="list-style-type: none"> • Feeling trusted and valued by the team • Allowed to get on with things at own pace. • Becoming part of the ward team 	<ul style="list-style-type: none"> • Feedback to ward teams the importance of knowing and treating the HCA as an individual – link to Trust values • Team building as part of ward development programmes
5.5.2.3. Key theme 2. 3: Positive Outlook	Positive affirmation of where I am	<ul style="list-style-type: none"> • Positive feedback from key individuals whom they respected is important 	<ul style="list-style-type: none"> • Ward teams to develop a culture that encourages positive feedback – Ward Sister feedback particularly important
5.5.2.4. Key theme2. 4: Sense of Self	I am still a carer	<ul style="list-style-type: none"> • First and foremost a carer. • .Being a carer has been an anchor whilst other things were new and changing 	<ul style="list-style-type: none"> • Acknowledgement of previous experience in caring • Emphasis on induction that whilst there are things to learn in terms of the acuity and the patients' medical condition – what they bring with them in terms of caring is important.

Appendix 24: What is already known- The literature reviews and their timescale in relation to the study.

